

COBRA CONTINUATION COVERAGE ELECTION FORM

(Return This Portion to Plan Administrator)

The following Qualified Beneficiary(ies) hereby elect COBRA continuation coverage:

To be completed by Qualified Beneficiary(ies)

NAME OF QUALIFIED BENEFICIARY	DATE OF BIRTH	MEDICAL PLAN	DENTAL PLAN	VISION PLAN

To be completed by Plan Administrator

PREMIUMS					
MEDICAL	SINGLE	\$	MEDICAL	EMPLOYEE	\$
	FAMILY	\$		EMPLOYEE + 1	\$
				EMPLOYEE + 2	\$
				EMPLOYEE + 3	\$
DENTAL	SINGLE	\$	DENTAL	EMPLOYEE	\$
	FAMILY	\$		EMPLOYEE + 1	\$
				EMPLOYEE + 2	\$
				EMPLOYEE + 3	\$
VISION	SINGLE	\$	VISION	EMPLOYEE	\$
	FAMILY	\$		EMPLOYEE + 1	\$
				EMPLOYEE + 2	\$
				EMPLOYEE + 3	\$

Send this form to _____
 Plan Administrator at: _____

To Be Completed By Qualified Beneficiary(ies)

I have read and understand this form and my COBRA election rights. I realize that if I elect continuation coverage and fail to pay the required premium on time, this coverage will terminate. I agree to notify the Plan Administrator if I, or any covered family member, becomes entitled to Medicare or covered under another group health plan.

Signature _____
 Please print your name _____
 Date _____
 Address _____
 Telephone _____

For internal use only

Received by Plan Administrator (initials) _____

Date _____