

continuation coverage. Important information about your rights is provided to you on the pages after the Election Form.

COBRA CONTINUATION COVERAGE ELECTION FORM

[Name of Employee / Spouse / Dependent Children (as appropriate)]

IMPORTANT: This form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*. Send completed form to:

[Enter Name and Address]

I (We) elect to continue our coverage in the *[enter name of plan]* (the Plan) as indicated below:

	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____

Type of coverage elected (check only one):

- ☐ *[enter description of option]*
- ☐ *[enter description of option]*
- ☐ *[enter description of option]*

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number