

# COBRA Continuation Coverage Election Form

**INSTRUCTIONS:** To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ [Enter name and address]

This Election 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]

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the Election Notice sent with this form.

I (We) elect COBRA continuation coverage in the \_\_\_\_\_ (the Plan) as indicated below:  
[Enter name of plan]

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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a. \_\_\_\_\_  
[Add if appropriate: Coverage option elected: \_\_\_\_\_ ]

b. \_\_\_\_\_  
[Add if appropriate: Coverage option elected: \_\_\_\_\_ ]

c. \_\_\_\_\_  
[Add if appropriate: Coverage option elected: \_\_\_\_\_ ]

\_\_\_\_\_  
[Signature]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Print name]

\_\_\_\_\_  
[Relationship to individual(s) listed above]

\_\_\_\_\_  
[Print address]

\_\_\_\_\_  
[Telephone number]