## Federal COBRA Election Form for Group Health Coverage



1. Date of notice	2. First date of no coverage 3. Last of			3. Last date to ele	st date to elect continuation		
	1 Mambasid						
To the Covered Family of:	1. Member identification						
	2. Group number						
	3. Group name						
4. Current home address (if different) - street	l address						
5. City	6. State		7. ZIP code		8. County		
9. Phone number	10. Email addı	ress					
Reason for termination of cov	erage (COBR	A qualifying ev	vent). Check o	one.	of event		
☐ Termination of employment (18 months)	Divorce	e/legal separation fr	om covered emplo	yee (36 months)			
☐ Reduction of work hours (18 months)	☐ Depen	dent child no longe	r eligible (36 month	ns)			
☐ Death of covered employee (36 months)	☐ Covere	d employee is Medi	care covered effec	tive	(36 months)		
As a participant whose coverage terminated due							
through COBRA. To elect COBRA continuation of maximum of 60 days after the date of this notice coverage under the Plan. You have a maximum 4! no coverage above. Benefits will not be reinstated Thereafter, full payments must be received by the month will result in suspension of benefits. Failur with no option for reinstatement.	e or from the first d 5 days from the dat ated until this form ne first (1st) of each	e this Election Form ate of no coverage, v e of your election to n and full payment is n month. You will not	and return it to you whichever is later, to make your first (1st) s received. receive a monthly:	r former employe decide whether y payment. <b>You mu</b> statement. Failure	r. Under federal lav ou want to elect CC st pay retroactive to make payment b	y, you must have a DBRA continuation to the first day of by the first of each	
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Note

- 1. Individuals who become covered under other group health insurance, including Medicare after the qualifying event are no longer eligible for COBRA continuation coverage.
- 2. Life insurance cannot be continued under COBRA. Contact your life insurance carrier or your former employer.
- 3. If you participate in a Flexible Spending Account, you may be eligible to continue for the remainder of the current plan year. Contact your former employer.
- 4. Employee Assistance Program (EAP) may be continued through COBRA. Contact your former employer.

## My signature below indicates that I understand the following:

- Payments must be submitted retroactively to the first day of no coverage.
- I am responsible for submitting monthly contributions by the first of each month to avoid suspension of coverage.
- · If my payment is not made within 30 days from the first of the month, my coverage will be terminated with no option to reinstate.
- I will not receive monthly billings.
- If I become covered by other group health plan including Medicare after electing COBRA, I am no longer eligible for COBRA continuation.

Signature of applicant	Date
Please return form and COBRA payment to:	