

COBRA ELECTION FORM

To be completed by Employee/Applicant (Please Print)

EMPLOYEE NAME _____ S.S.# ____/____/____

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____

PHONE: WORK () _____ HOME () _____

INDICATE QUALIFYING EVENT:

DATE OF QUALIFYING EVENT ____/____/____

- Termination of Employment
 Reduction in Work Hours
 Death of Employee

- Divorce or Legal Separation
 Medicare Eligibility
 Termination of Dependent Eligibility

EMPLOYEE SIGNATURE _____

INDICATE COVERAGE SELECTION:

Medical Coverage

___ I (We) elect **NOT** to continue coverage under the Group Medical Plan for:
___ Myself ___ My Spouse ___ My Dependent(s)

___ I (We) elect to **CONTINUE** coverage under the Group Medical Plan for:
___ Myself ___ My Spouse ___ My Dependent(s)

Dental Coverage

___ I (We) elect **NOT** to continue coverage under the Group Dental Plan for:
___ Myself ___ My Spouse ___ My Dependent(s)

___ I (We) elect to **CONTINUE** coverage under the Group Dental Plan for:
___ Myself ___ My Spouse ___ My Dependent(s)

Spouse's Name _____ S.S.# ____/____/____ DOB ____/____/____

Spouse's Street Address _____

City _____ State _____ Zip Code _____

Dependent(s): (The Employee or Spouse MUST complete for all minors)

Dependent Name _____ S.S.# ____/____/____ DOB ____/____/____

Dependent Name _____ S.S.# ____/____/____ DOB ____/____/____

Dependent Name _____ S.S.# ____/____/____ DOB ____/____/____