

COBRA ELECTION FORM

Employee's Name

Name of Plan or Company

Employee's Social Security Number

I elect to receive continued coverage under the Employee Health Plan. I would like to continue my benefit package for the following plan(s):

_____ Medical _____ Prescription _____ Dental _____ Vision

I understand that the current cost per month will be: \$ _____

I would like to continue benefits for my eligible dependents. Yes _____ No _____

If yes, please give their names, birth dates and relationship to you.

Name	Birth Date	Relationship to Applicant
1.		
2.		

If you have additional dependents, please list on reverse side of this form.

I understand that this election must be filed with the Administrator within 60 days of coverage termination date. I also understand that this form must be filled out completely. An incomplete form may delay processing of my election and continued health coverage.

	<u>Yes</u>	<u>No</u>
My first payment (including all retroactive payments) is enclosed.	<input type="checkbox"/>	<input type="checkbox"/>
You will receive my first payment within 45 days.	<input type="checkbox"/>	<input type="checkbox"/>
Is the applicant covered under any other group health plan, including Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
Is the applicant's spouse covered under any other group health plan, including Medicare?	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Name of Applicant

Applicant's Social Security Number

Relationship to Employee

Please return this form to the Administrative service office in your area.

ALHAMBRA: P O BOX 1121 • BENEFIT INFORMATION CENTER • ALHAMBRA, CA 91802-1121
SAN DIEGO: 4666 MISSION GORGE PLACE #1 • SAN DIEGO, CA 92120
LAS VEGAS: P O BOX 26509 • LAS VEGAS, NV 89126-6509