

COBRA Worksheet (for Employer Records Only)

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: _____

This Election Form must be completed and returned by mail or hand delivery on _____.

If mailed, it must be post-marked no later than _____.

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. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date that your group health plan coverage terminated.

**READ THE IMPORTANT INFORMATION PROVIDED ABOUT YOUR
 COBRA CONTINUATION COVERAGE RIGHTS (included in COBRA Election packet MKT-171)**

I (We) elect **COBRA** continuation coverage in the following group health plans (the plan) as indicated below:

Type of plans (please check): **Health** **Dental** **Vision**

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER ____-____-_____
DATE OF BIRTH (MM/DD/YYYY) ____/____/_____	RELATIONSHIP TO EMPLOYEE		

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER ____-____-_____
DATE OF BIRTH (MM/DD/YYYY) ____/____/_____	RELATIONSHIP TO EMPLOYEE		

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER ____-____-_____
DATE OF BIRTH (MM/DD/YYYY) ____/____/_____	RELATIONSHIP TO EMPLOYEE		

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER ____-____-_____
DATE OF BIRTH (MM/DD/YYYY) ____/____/_____	RELATIONSHIP TO EMPLOYEE		

Type of coverage elected (please check one only):

- I (We) elect to continue family coverage under the plan
- I (We) elect to continue single coverage under the plan
- I decline/waive my right to COBRA continuation coverage under the plan

SIGNATURE	PRINT NAME	DATE
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PRINT ADDRESS	TELEPHONE NUMBER
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RELATIONSHIP TO EMPLOYEE
