Election of COBRA Continuation Coverage (For Employee, Spouse and Dependent Child(ren) Upon Employee's Termination of Employment or Reduction in Hours of Employment)

Name: _____ Date: _____

Address: _____ SS#: _____

Address: _____

City/State: _____ Zip: _____

This Election form must be received by the Plumbing Industry Board no later than _____ or you will lose your right to elect COBRA Continuation Coverage under the Plumbers Local Union No. 1 Welfare Fund.

❑ I elect COBRA Continuation Coverage consisting of comprehensive major medical, surgical and hospitalization benefits, vision, prescription and dental benefits for myself at a cost of $_____ per month.

❑ I elect COBRA Continuation Coverage consisting of comprehensive major medical, surgical and hospitalization benefits, vision, prescription and dental benefits for myself and my family at a cost of $_____ per month.

❑ I reject COBRA Continuation Coverage.

❑ My initial premium is enclosed.

❑ My initial premium will be sent within 45 days of the date of this Election Form.

_____ _____
Name of Person Electing Relationship to Participant

_____ _____
Signature of Person Electing Date

_____
Mailing Address

_____

Note: Under Federal law, you need not elect COBRA Continuation Coverage for your entire family. The employee, spouse and dependent child(ren) each have a separate right to elect COBRA Continuation Coverage. However, since there is one composite rate premium for COBRA Continuation Coverage, there is no advantage to electing COBRA Continuation Coverage for fewer persons then are entitled to coverage.