COBRA CONTINUATION COVERAGE ELECTION FORM

This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than 60 days from the date indicated on the enclosed COBRA Notice/

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 Welfare Fund of Engineers Local 513, 3449 Hollenberg Dr, Suite 150 Bridgeton, MO 63044.
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. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.
Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the Engineers Local 513 Welfare Fund as indicated below:

1. Qualified Beneficiary's Name (Last, First, Middle Initial) _____

2. Qualified Beneficiary's Social Security Number _____

3. Employee's Social Security Number (If Qualified Beneficiary is Other Than Terminated Employee) _____

4. Qualified Beneficiary's Date of Birth: _____

5. Qualified Beneficiary's Address (Street, City, State, Zip Code) _____

6. Phone Number _____

7. I request continuation of the following coverage:

Coverage is for:
☐ Self & Spouse ☐ Self, Spouse & Child/Children
☐ Self & Child/Children ☐ Child Only
☐ Spouse & Child/Children ☐ Self Only ☐ Spouse Only

If you or any of your dependents are covered under another Group Health Plan, please indicate Type of Coverage, Health Plan Sponsor and Family Members Covered.

_____

_____

Coverage type: ☐ Medical **ONLY** ☐ Medical, Dental and Vision

8. Dependent Qualified Beneficiaries, (If Applicable)

Name (First, Middle Initial, Last)	Relationship	Social Security Number	Date of Birth

Qualified Beneficiary's Signature:_____Election Date: _____

Revised 10/2014