

# COBRA CONTINUATION ELECTION FORM

I wish to continue coverage under the <Name of Company> Employee Benefit Plan. I understand that this election is subject to the Plan. I have read and understand the COBRA Continuation Coverage Notice and the letter that accompanied this election form and both COBRA rights and limitations on those rights.

YES  NO

**IF YES, PLEASE ATTACH A NEW APPLICATION**

**Effective date of continuation coverage:** \_\_\_\_\_

**First payment is enclosed:**  YES  NO

(If first payment is not enclosed, you may not be able to access health care coverage until payment is received.)

**Qualifying Event:**

Termination  Death  
 Reduction in hours  Divorce  Other \_\_\_\_\_

**Type of Insurance Selected:**

Health  Dental  Vision

(May not add lines of Insurance until Open Enrollment.)

**Type of Coverage Selected:**

Individual  Husband/Wife  Parent/Child  Family

(Dependents may not be added until Open Enrollment unless a change in family status occurs.)

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name Social Security Number

\_\_\_\_\_  
Signature of Witness

**For Employer to complete:**

Continuation coverage end date: \_\_\_\_\_

Bill to Company:

Bill to Qualified Beneficiary:

\_\_\_\_\_  
Billing address

\_\_\_\_\_  
City State Zip