COBRA ELECTION FORM

I elect COBRA Continuation coverage and agree to remit payment of all premiums due on a timely basis to the Trust Office.

I AM ELECTING: (Check one box only)

☐ **Full Benefits**- Medical, Dental and Vision (No Life Insurance)

☐ **Core Benefits Only**- Medical Only

The persons covered under Continuation coverage are:

Full Name	Relationship	Date of Birth	Address (if different than yours)	Eligible for / or Enrolled in Medicare or Other Coverage? (Name of Company)
	Self/Employee			
	Spouse			

When Continuation coverage May Terminate:

1. Non-Payment of premium in full by the end of the grace period;
2. The person is/becomes covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such person;
3. The person becomes entitled to Medicare benefits;
4. For Dependents Only--The Spouse or Child ceases to be a Covered Dependent and does not timely elect their own Continuation coverage. Also upon the death or divorce of the Covered Employee after the initial qualifying event, Continuation coverage shall immediately terminate for a Covered Dependent who was not a Covered Person before Continuation coverage first began;
5. For Disabled Persons -- the person is no longer Totally Disabled as finally determined by the Social Security Administration; or
6. The Trust stops providing any group health benefits to all Covered Persons.

BY SIGNING THIS ELECTION FORM YOU AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL PREMIUMS, WHEN DUE, ON A TIMELY BASIS FOR WHICH YOU WILL NOT BE BILLED.

______________________________ **Signature of Person Making Election**

______________________________ **Print your name**

________ **Date**

______________________________ **Telephone Number**

______________________________ **Social Security Number**