ELECTION ENROLLMENT INFORMATION

TEMPORARY CONTINUATION OF GROUP MEDICAL AND DENTAL/OPTICAL COVERAGE

This Form must accompany COBRA Form #87 GMS 12/87 when making application for continuation of coverage.

SECTION I: Election Information

EMPLOYEE ELECTION - As a covered employee who has lost or will lose coverage under my employer sponsored health plan resulting from a qualifying event, I choose to elect continued coverage as indicated:

☐ Myself only ☐ Myself and dependents ☐ Dependents only X _____

Your Signature Date

QUALIFIED BENEFICIARY ELECTION ☐ YES, as a qualified beneficiary who has lost or will lose coverage as the result of a qualifying event, I choose to elect continued coverage.

A qualified beneficiary is a spouse or dependent, not an EMPLOYEE, who has or will lose coverage due to a qualifying event. X _____

Your Signature Date

* An election by the spouse may consitute election for all dependents living with the spouse at the time of the event.

** A dependent child who ceases to be a dependent as defined under the health plan must indivually elect, except in the case of a minor.

INITIAL PREMIUM CALCULATION (Example Only)

- Initial premium payment MUST include ALL 30 day periods which have elapse since your coverage terminated PLUS the current month for which you have elected coverage.
- If you terminated coverage January 1, elected continuation coverage February 28, made first payment March 10, your 1st payment must allow for (3) months coverage. (Jan. 1 - Feb. 1, Feb. 1 - Mar. 1 (elapsed period) plus Mar. 1 - Apr. 1 (current month) the next premium would be due April 1 to cover April 1 - May 1.

SECTION II: Enrollment Information

EMPLOYER PLAN | EMPLOYEE | SOCIAL SECURITY NO.

EMPLOYER ADDRESS | CITY, STATE, ZIP | PHONE

SPOUSE | DATE OF BIRTH | SOCIAL SECURITY NO.

SPOUSE ADDRESS (If different) | PHONE

NAME(S) OF ELIGIBLE DEPENDENTS	DATE OF BIRTH	INDICATE WHICH APPLIES	
		FULL-TIME STUDENT	LIVES AT HOME**

**Give Address If Not Living At Home

ANSWER THE FOLLOWING QUESTIONS:

A) Are you or any of your dependents eligible for Medicare coverage? ☐ YES ☐ NO If Yes, list _____

B) Are you or any of your covered dependents employed? ☐ YES ☐ NO If Yes, list their names and employers.

C) Are you or any of your covered dependents covered under any other health coverage? ☐ YES ☐ NO If Yes, list source of coverage and when coverage began: _____

I certify all of the above information to be true and correct to the best of my knowledge and to comply and conform to all normal plan provisions. I agree to reimburse the plan any and all benefits paid to me, my dependents or to any other party on my behalf, if it is determined I or my dependent(s) were not entitled to such benefits.

Signature Date