

COBRA CONTINUED COVERAGE ELECTION

___ I **DO** elect to continue coverage under the Group Contract. I understand that my first subscription charge for continuation coverage must be received within 45 days of the date of this election and that all subsequent monthly subscription charges must be received by the first day of each month.

Name: _____ SSN: _____ Birthdate: _____

Address: _____ Phone: _____ City: _____

State: _____ Zip: _____ Employer Name: _____

1, 2 or 3 party coverage _____. If you are enrolling for 2 or 3 party coverage, please list dependents names and birth dates.

NAME	BIRTH DATES \ \	SSN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I qualify for continued coverage for the following reason:

- ___ Termination of employment (other than for gross misconduct)
- ___ Reduction of hours required in group contract
- ___ Divorce or separation from covered employee,
Name: _____ SSN: _____
- ___ Death of covered employee:
Name: _____ SSN: _____
- ___ No longer qualify for dependent status in group contract.
Dependent of: _____ SSN: _____

Date above occurred: _____

I am not presently covered by any other group plan and understand I must notify the Plan Administrator should I become eligible for benefits under another group coverage or Medicare.

I understand that premium is due the first of every month and coverage may be terminated if premium is not received on or before the 10th of every month.

Applicant Signature

Date