

IBEW LOCAL NO 9 LINE CLEARANCE CONTRACTORS HEALTH & WELFARE FUND

ELECTION FORM COBRA CONTINUATION COVERAGE

I have read and understood the provisions for continuing coverage. I elect COBRA CONTINUATION COVERAGE as described below. I understand that no Disability Benefits or Death Benefits of any type are provided with COBRA CONTINUATION COVERAGE.

(It is the intent of the Board of Trustees to periodically review the self-payment rates and make appropriate adjustments.)

Please respond to the following questions:

Are you or any of your dependents currently covered by another group health care plan(s)? Yes No

If YES, indicate name of plan(s): _____

If YES, list names of dependents covered by other plan(s):

Are you or any of your dependents currently eligible for Medicare benefits? Yes No

I, the undersigned, elect to purchase the following **COBRA CONTINUATION COVERAGE**:

Medical only at the rate of \$651.00 per month (C4)

Medical and Vision Benefits only at the rate of \$660.00 per month (C3)

Medical and Dental Benefits only at the rate of \$708.00 per month (C2)

Medical, Vision and Dental Benefits at the rate of \$717.00 per month (C1)

Participant's Name (Please Print)

Member ID or SS#

Participant's Signature

Date Signed

Spouse's Signature

Amount Enclosed

LIST INDIVIDUALS TO BE COVERED (Use reverse side, if necessary)

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____