

Sample Cal- Cobra Election Form

(For employers with less than 20 employees)

See Reverse For Cobra Election Form

(For employers with more than 20 employees)

You are eligible to continue any of the following plans:

CHOICE ONE:

High Deductible Medical Plan. Refer to your insurance carriers Evidence of Coverage booklet for a full description of your benefits.

You will be notified by our insurance carrier of your Cobra continuation rights and your cost to continue coverage under the High Deductible Medical Plan.

CHOICE TWO

High Deductible Medical Plan **with** Self-Funding

If you chose to continue coverage under the High Deductible Plan you may also continue coverage and self-fund your plan. Current charges that are applied to the High Deductible Medical Plan are self-insured. Refer to your current Summary Plan Description and Schedule of Benefits.

Monthly Premium: *(Employer: insert below the self-insured premium (see chart below) + your Ben-e-lect administration fee)*

Carrier Deductible	Single Insured	2 or More Insured's
2500/5000	208.34	416.67

Cost to Continue with Self-Funding

	<i>Self-Funded</i>	<i>Admin Fee</i>	=	<i>Total</i>
Employee	_____	_____		_____
Family	_____	_____		_____

The above cost will be in addition to the premium that you pay to our insurance carrier. You will pay the cost of the self-funded plan directly to the employer.

Please indicate the individuals that will be continuing coverage under the High Deductible Self-Funded plan. These individuals must have been covered at the time of the qualifying event.

Name	SS #	Date of Birth	Relationship

Sign to accept Choice Two _____ Date _____