Sample
Cal- Cobra Election Form

(For employers with less than 20 employees)

You are eligible to continue any of the following plans:

CHOICE ONE:
Basic Hospital PPO 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 Basic Hospital Plan.

CHOICE TWO:
Basic Hospital Plan with Self-Funding
If you chose to continue coverage under the Basic Hospital Plan you may also continue coverage and self-fund your plan. Refer to your current Summary Plan Description and Schedule of Benefits for benefits that are self-insured.

Monthly Self-Funded Premium: *(Call Ben-e-lect for premiums)*

Cost to Continue with Self-Funding

	Self-Funded	*Admin Fee*	=	*Total*
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 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______________________