

# 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
2250/4500	187.50	375.00

*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 \_\_\_\_\_