

Sample Cobra Election Form

(For employers with 20 or more 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.

Monthly Premium: *(Employer: insert below the premium you are currently being charged by your insurance carrier) (The premiums you are being charged by your insurance carrier are based upon the employees age. If you need a premium that does not include the employee such as a spouse only cost, a child(ren) only cost or a spouse & child(ren) only cost, please call your insurance carrier).*

Employee Only _____
Employee & Spouse _____

Employee & Child(ren) _____
Employee, Spouse & Child(ren) _____

CHOICE TWO – High Deductible 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 Summary Plan Description and Schedule of Benefits.

Monthly Premium: *(Employer: insert below the premium you are currently being charged by your insurance carrier + self-insured premium (see chart below) + your Ben-e-lect administration fee)*

Carrier Deductible	Single Insured	2 or More Insureds
2250/4500	187.50	375.00

	<i>Premium</i>	<i>Self-Funded</i>	<i>Admin Fee</i>	=	<i>Total</i>
Employee	_____	_____	_____		_____
Employee & Spouse	_____	_____	_____		_____
Employee & Child(ren)	_____	_____	_____		_____
Family	_____	_____	_____		_____

Please indicate the individuals that will be continuing coverage under either Choice One or Choice Two. These individuals must have been covered at the time of the qualifying event.

Name	SS #	Date of Birth	Relationship

I wish to continue coverage under _____
Choice One Only
Choice Two

Sign to accept _____ Date _____