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 anther 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 – Contact Fund Office for appropriate rate

______**Medical and Vision Benefits** only – Contact Fund Office for appropriate rate

______**Medical and Dental Benefits** only – Contact Fund Office for appropriate rate

______**Medical, Vision and Dental Benefits** – Contact Fund Office for appropriate rate

____________________ ____________________

Participant's Name (Please Print) Participant's ID# or Social Security Number

____________________ ____________________

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