COBRA ELECTION FORM

I, _____, understand that on _____/_____/_____, my coverage under the Southwest Ohio Regional Council of Carpenters Health and Welfare Fund will terminate unless I elect continued coverage within 60 days of the letter of _____/_____/_____(Date on which notice was mailed) or my loss of coverage under the Fund.

In accordance with the provisions of the Consolidate Omnibus Budget Reconciliation Act (COBRA), I am eligible to continue coverage for myself and any of my eligible dependents for the total of _____months from _____/_____/_____to _____/_____/_____.

I further understand that if I elect such continued coverage, I am responsible for the payment of the cost of such coverage, and that I must pay $581.00 for single participants or $791.00 for family participants within 45 days of the date I file this election with the Administrative Office. Furthermore, I understand that all subsequent payments are due on the 2nd of the month. Failure to pay the premium will result in cancellation of coverage and terminate and further continuation of coverage rights. While a grace period of up to 3 days may be allowed for payment of premium, any health coverage is suspended until my payment is received.

After being sufficiently informed of my right to continue coverage, I

☐ Elect to continue coverage under the Southwest Ohio Regional Council of Carpenters Health and Welfare Fund by paying the required monthly premium of **$581.00 for single participants**, and providing the Administrative Office with the necessary information to continue my coverage.

☐ Elect to continue coverage under the Southwest Ohio Regional Council of Carpenters Health and Welfare Fund by paying the required monthly premium of **$791.00 for family participants**, and providing the Administrative Office with the necessary information to continue my coverage.

☐ Elect not to continue coverage under the Southwest Ohio Regional Council of Carpenters Health and Welfare Fund.

NOTE – Each qualified beneficiary has a right to elect continuation coverage independently. Except as otherwise specified, any election made by the employee or employee's spouse shall be deemed to include an election on behalf of all other qualified beneficiaries who would lose coverage under the Plan by reason of the qualifying event. A parent or legal guardian may elect continuation coverage on behalf of a minor child.

Additionally, I verify on the date that I lost eligibility for coverage under the Southwest Ohio Regional Council of Carpenters Health and Welfare Fund, I (and any other Qualified Beneficiary) was not covered by any other insured or uninsured arrangement that provides health care coverage for professional services, appliances, and supplies for individuals or under a group arrangement.

I further agree to notify the Administrative Office immediately if I become covered under any other insured or uninsured arrangement that provides health care coverage for professional services, appliance, and supplies for individuals or under a group arrangement.

_____ _____ _____
Participant Signature Social Security Number Date

_____ _____
Participant's Spouse Date

_____ _____
Participants' Dependent Date

_____
Date Group Coverage Terminates