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COBRA CONTINUATION COVERAGE ELECTION FORM

You, your spouse/eligible domestic partner and eligible dependents can each choose either:

- CORE coverage - which provides medical benefits only or
- CORE PLUS coverage, which provides medical, dental and vision benefits.

I
f **anyone** in your family chooses CORE PLUS, **everyone** will be covered under CORE PLUS, since you will pay the CORE PLUS premium.

If you are a **retiree** under the plan, you may also choose to cover either the retiree only, or the retiree and family.

PREMIUM RATES: Effective April,			
		RETIREES: (no dental included)	
		Retiree Only	Retiree & Family
CORE: Medical Only	$	$	$
COREPLUS: Medical, Dental, Vision	$	$	$

INSTRUCTIONS: You, your spouse/eligible domestic partner, and each eligible dependent is to fill in name, social security number, and place his or her initials in the box for the coverage elected. A guardian must complete this form for eligible dependents under age 18.

NAME	SSN	SIGNATURE	CORE	CORE PLUS	RETIREE ONLY	RETIREE & FAMILY

FAILURE TO ANSWER THIS QUESTION CAN DELAY PROCESSING OF THIS ELECTION FORM

I understand that a monthly payment is required for each person who elects the COBRA Coverage indicated above. I (or my dependents) will be billed for the cost of COBRA Coverage from the date my regular coverage stopped.

_____ _____
Signed Date

Daytime telephone number: _____