Committee of Interns and Residents
SEIUHealthcare

HOUSE STAFF BENEFITS PLAN

520 EIGHTH AVENUE, SUITE 1200, NEW YORK, NY 10018-4181

Phone: (212) 356-8180 Fax: (212) 356-8181 benefits@cirseiu.org http://www.cirseiu.org

COBRA CONTINUATION COVERAGE ELECTION FORM

Instructions: To elect COBRA Continuation Coverage, complete this Election Form and return it to us. Please refer to the enclosed document entitled "Important Additional Information About Your COBRA Continuation Rights" before completing this form. Under Federal law, you have 60 days from the date on which you lose (or would lose) your coverage as a result of your Qualifying Event (the event that caused the loss of coverage under the House Staff Benefits Plan) to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: House Staff Benefits Plan
520 Eighth Avenue, Suite 1200
New York, NY 10018
(E) benefits@cirseiu.org
(F) (212) 356-8181

- **This Election Form must be completed and returned by mail, email or by fax at (212) 356-8181. If mailed, it must be post-marked no later than 60 days after your termination date.**
- **If you do not submit a completed Election Form you will lose your right to elect COBRA Continuation Coverage.**
- **Read the important information about your rights included in the pages after the Election Form.**

I (We) elect COBRA Continuation Coverage in the House Staff Benefits Plan (the "Plan") as indicated below. (Check one premium rate only):

Based on your present insurance coverage, you are eligible for the following COBRA Continuation Coverage:

COBRA OPTIONS	INDIVIDUAL	FAMILY
( ) **Managed Dental Guard (MDG)**	$ 60.39	$ 161.96
( ) **Dental Guard Preferred (DGP)**	$ 71.26	$ 195.41

You should be aware that the price of COBRA Continuation Coverage is likely to change annually.

Name Date of Birth Relationship to Employee SSN

a. _____

b. _____

c. _____

d. _____

[ ] I enclose $_____in payment of my first monthly premium, plus, if applicable, any previous months owed. (If I have not included a check or money order(s) with this Election Form or elected to pay by credit or debit card below, payment must be sent within 45 days in order to be timely. If payment is not received or postmarked within 45 days of the date of this form, I will no longer be eligible for COBRA Continuation Coverage) The Benefits Plan Office will not send me monthly bills. Payments of the premiums each month will be solely my responsibility. I understand that if I do not submit payment for the first month of coverage with this form or elect to pay by credit or debit card below, my coverage will not be continued until timely payment is received and will terminate as scheduled. I understand that upon the Plan's receipt of payment (within 45 days), my coverage will be reinstated retroactively to the date my coverage terminated or was scheduled to terminate.

After the initial COBRA payment, I further understand that subsequent monthly premium payments are due on or before the first day of the month of coverage to which it applies. There is a 30-day grace period to make monthly periodic payments. If payment is not received on or before the first day of the month, my coverage will be terminated as of the end of the period for which the last premium payment was remitted. If I thereafter make a monthly periodic payment in full later than the first day of the month to which it applies but before the end of the 30-day grace period (the first 30 days of that month), my coverage will be reinstated retroactively to the first day of that month. If any monthly premium payment is not received or postmarked within 30 days of the first day of the month to which it applies, I will automatically cease to be covered as of the end of the period for which the last premium payment was remitted and will have no right to reinstatement of my benefits.

[ ] I have filled out the Credit Card Authorization Form included in this notice and authorize the Plan to deduct my first monthly premium, and any premiums thereafter, according to the information provided on my application.

Member Signature: _____ Date:_____