

COBRA Continuation Coverage Election Form

Instructions: Under the American Recovery and Reinvestment Act you are only entitled to elect COBRA continuation coverage at this time if you lost dental, vision, and/or Piggyback coverage under the Trust due to an involuntary termination of employment during the period that begins with September 1, 2008 and ends with December 31, 2009. You may only elect the coverage you had on the day before the qualifying event. To elect COBRA continuation coverage, complete this Election Form and return it. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send the completed Election Form to:
 CCPOA Benefit Trust Fund
 2515 Venture Oaks Way, Suite 200
 Sacramento, CA 95833-4235

This Election Form must be completed and returned by mail, if mailed, it must be post-marked no later than 60 days after the date of this notice.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage.

I (We) elect COBRA continuation coverage into the plan as indicated below:	
Name:	Birthdate:
Relationship to Employee:	Social Security (Last 4)
Coverage option(s) (i.e., Dental, Vision, and/or Piggyback coverage):	
Name:	Birthdate:
Relationship to Employee:	Social Security (Last 4)
Coverage option(s) (i.e., Dental, Vision, and/or Piggyback coverage):	
Name:	Birthdate:
Relationship to Employee:	Social Security (Last 4)
Coverage option(s) (i.e., Dental, Vision, and/or Piggyback coverage):	
Signature:	Date:
Print Name:	Relationship(s) to individual(s) listed above
Address:	Telephone:
City:	State: ZIP:

CCPOA Benefit Trust Fund
 2515 Venture Oaks Way, Suite 200 • Sacramento, CA 95833-4235
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