COBRA ELECTION FORM

Employer Name: _____
Name of the Employer Sponsoring the Group Health Plan

Employee Name: _____ SSN: _____
Name of the Employee who was originally covered under the Employer's Group Health Plan

Information About The Person Completing This Form:

Your Name: _____ Relationship to Employee:

Address:_____ _____

City State Zip:_____ Ph: _____

E-mail:_____

List Each Qualified Beneficiary In Your Family Electing COBRA

Name	Date of Birth	Social Security Number	Relationship To Employee

Benefit Plans Elected:

Description	Coverage Description*	Premium Cost
	CHOOSE ONE	
	CHOOSE ONE	
	CHOOSE ONE	
	CHOOSE ONE	
	CHOOSE ONE	
Total Premiums		$0.00

* Coverage Description is the "tier" or level of coverage. For example, you might choose to elect Group Health coverage for your FAMILY but choose Dental only for the EMPLOYEE. You can only elect coverage that existed prior to the COBRA Qualifying event. Use additional pages if necessary.

Per my rights under COBRA, I have elected to continue benefits under the plans listed above and acknowledge that I am responsible for the associated premiums. I have read and understand the information presented in this document and my responsibilities under the law. I understand that I may have to complete additional paperwork and agree to return them as instructed. I understand that my COBRA election is subject to receipt of the initial premiums within 45 days of this enrollment and my coverage will not be reinstated until the initial premiums are received. I also am aware this election is binding and once enrolled, I will not be able to make changes (unless a change in life status event occurs) until the next Open Enrollment. I hereby certify that neither myself nor my covered dependents have become covered, enrolled or insured under any other group health plan after our coverage ended under the Employer's group plans.

Signature: X_____ **Date:** _____

FAX COMPLETED FORM TO (888) 313-0401 or MAIL TO FlexToday, Inc., PO Box 16099, Fresno, CA 93755

If you complete this form electronically or scan the completed form to Acrobat, **click here** to post to the Secure Portal.

(Adobe Acrobat Only – Include Your Name and the Group Health Plan Sponsor (Employer) Name In The Add-A-Message Area.)
If you have Adobe Acrobat, your signature can be made electronically. The electronic signature does not work in Adobe Reader.