COBRA Continuation Coverage Election Form
(Death, Divorce, Legal Separation, Medicare Entitlement, Loss of Dependent Status)

Date of Notice: ___________

Mailed: ___________

Hand Delivered: ___________

Qualified Beneficiary Information:

Name: Last, First, Middle: ______________________________ Social Security Number: ____________________

Home Address: ______________________________ City: ______________ State: ______ Zip: __________

Date of Birth: ______________ Marital Status: ________ Single ______ Married ______ Divorced ______ Widowed ______

Number of Dependent Chidren: ____________ Date of Hire: ____________ Health Coverage Policy Number: ______________________

Entitlement to COBRA Coverage

As explained in the notice of rights accompanying this form, you are entitled to continue health coverage under the Pawtucket School Department's group health plan due to the following qualifying event, which became effective on : _____________

_______ Your spouse's death

_______ Your divorce or legal separation

_______ Your spouse became entitled to Medicare

_______ Your dependent is no longer eligible for coverage

This qualifying event will result in the loss of health coverage unless you elect continuation coverage. If you would like to elect continuation coverage, please read and sign this form and return it to the Pawtucket School Department s' Plan Administrator as soon as possible.

If this election form is not returned within 60 days from the date of this notice, you will lose your right to elect coverage, and your coverage under the Pawtucket School Department's group health plan will terminate effective: ____________

Continuation coverage under COBRA is provided subject to your eligibility. The Pawtucket School Department reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

Length of COBRA Coverage

You are eligible to receive up to 36 MONTHS of continuation coverage from the date of qualifying event. However, coverage may extend beyond that period or terminate early, as explained in your election notice.

COBRA Coverage Premiums

Within 45 days after the date that you elect COBRA coverage, you must pay an initial premium, which includes:

* The period of coverage from the date of your qualifying event to the date of your election.
* Any regularly scheduled monthly premium that becomes due between your election and the end of the 45 day period.

Once the Pawtucket School Department Plan Administrator receives this election form, you will be notified of the amount of the initial premium you must pay. If you fail to pay the initial premium, or any subsequent monthly premium, in a timely fashion, your coverage will terminate.

Premium payments are generally due within 30 days after the first day of each month of coverage. Premium amounts change from time to time. You will be notified of any change in the premium amount.

You are eligible for ________________ coverage. Unless you expressly elect otherwise, this coverage will be continued for you (and your spouse and dependent child(ren), if any). The regular cost of coverage will be as follows:

Family Coverage	Single Coverage
$____________ per month	$____________ per month

IF PREMIUM PAYMENT IS NOT RECEIVED ON TIME, COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED.

COBRA Coverage Election

I have read this form and the notice of my election rights. I understand my rights to elect continuation coverage and would like to take the action indicated below. I understand that if I elect continuation coverage and I fail to pay any premium payment on time, this coverage will terminate. I also agree to notify the Pawtucket School Department's Plan Administrator if I or any member of my family become(s) covered under another group health plan or entitled to Medicare after thedate of the COBRA election.

Please check ONE only.

________ I elect to continue FAMILY coverage under the plan.

List dependents to be covered:

Relationship	Name	Date of Birth

________ I elect to continue SINGLE coverage under the plan

Relationship	Name	Date of Birth

________ I have read this form and notice of rights. I am waiving my right to continuation coverage under the plan.

Signature: ____________________________________ Date: ________________

Name (Please Print): ____

Address: ____

Telephone: ____

Send Form To:

If your last position held was Teaching or Administrative, send here:

Pawtucket School Department
Attn: Teaching Benefits Coordinator
79 1/2 Park Place, P.O. Box 388
Pawtucket, RI 02860

If your last position held was Non-Teaching send here:

Pawtucket School Department
Attn: Non-Teaching Benefits Coordinator
79 1/2 Park Place, P.O. Box 388
Pawtucket, RI 02860

Make Inquires to:

(401) 729-6341 for Teaching Benefits questions

(401) 729-6342 for Non Teaching Benefits questions

For Office Use Only:

Beneifits Coordinator: ______________________________ Date Form Received: ___________________