KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND
1996 BYPASS SOUTH
LAWRENCEBURG, KENTUCKY 40342

Telephone: (800) 598-7330 **Fax Number: (502) 859-0976**

COBRA ELECTION FORM - CONSTRUCTION
(THE FOLLOWING MUST COMPLETED BY THE QUALIFIED BENEFICIARY)

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to the Fund. Under federal law, you must 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: Kentucky Laborers District Council Health and Welfare Fund at 1996 Bypass South, Lawrenceburg, KY 40342, (502) 839-8166. This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than 60 days from the date indicated on the enclosed COBRA 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. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form. Read the important information about your rights included in the enclosed notices.

S E C T I O N 1

I HAVE READ AND UNDERSTAND THE NOTICE OF RIGHT TO CONTINUE GROUP HEALTH COVERAGE AND:
(You MUST check Y one of the following)

	A	**I, the Employee, elect to NOT continue this Plan coverage for myself and my eligible dependents.**

(If you checked AA@, please sign below and return form to Fund Office)

Signed:____ Dated:__________________________

	B	**I, the Employee, elect to continue Plan coverage for my eligible dependents and/or myself.**

(If you checked "B", you **MUST** complete **Sections 2 and 4** of this form. The COBRA Election Form must be completed in full, signed, dated and returned to the Fund Office by the deadlines specified in the enclosed COBRA Notices.)

	C	**I (We), Eligible Dependent(s), elect to continue Plan coverage for person(s) listed in Section 4 of form.**

(If you or your Eligible Dependent(s) checked "C", you or your Eligible Dependent(s) **MUST** complete **Sections 3 and 4** of this form. The COBRA Election Form must be completed in full, signed, dated and returned to the Fund by deadlines specified in enclosed COBRA Notices.)

S E C T I O N 2
FOR EMPLOYEES CONTINUING COVERAGE FOR THEMSELVES AND THEIR ELIGIBLE DEPENDENTS

1	**TYPE OF COVERAGE ELECTED FOR FULL TERM OF COBRA CONTINUATION COVERAGE** **(You MUST check Y one of the following)**	
	Composite - Core/Non-Core	Medical, Vision, Dental [Employee & Dependents] Life, Accidental Death & Dismemberment [Employee only]
	Composite - Core/Non-Core (Due to Total Disability as determined by Social Security Administration*)	Medical, Vision, Dental [Employee & Dependents] Life, Accidental Death & Dismemberment [Employee only]

2	**COBRA PAYMENTS (See enclosed billing for correct monthly amount)**
1st Payment Total: **$**___________	1st COBRA Payment is made for following months of coverage: **From:** **To:**

NOTE: Payments will only be accepted in the form of personal check, money order or cashier=s check.
Payments may be made by the Qualified Beneficiary or another party.

* If you have elected continuation of COBRA due to Total Disability, you MUST attach a copy of your Social Security Disability Award. If you qualify for COBRA due to Total Disability, your COBRA period may be extended to 29 months.

However, it should be noted that the monthly COBRA self payment rate will increase for the 25th through 29th month.

SECTION 3
FOR DEPENDENTS CONTINUING COVERAGE DUE TO SEPARATE QUALIFYING EVENT
(Due to qualifying event such as divorce, death of member, dependent child no longer eligible for coverage, etc.)

1	TYPE OF COVERAGE ELECTED FOR FULL TERM OF COBRA CONTINUATION COVERAGE

Composite - Core/Non-Core	Medical, Vision, Dental [One or More Dependents]

2	COBRA PAYMENTS (See enclosed billing for correct monthly amount)	
	First Payment Total $_______________	First COBRA Payment is made for the following months of coverage: **From:** **To:**

NOTE: Payments will only be accepted in the form of personal check, money order or cashier=s check. Payments may be made by the Qualified Beneficiary or another party.

SECTION 4
LIST ALL PERSONS CURRENTLY ELIGIBLE WHO WISH TO CONTINUE COVERAGE
(If additional space is needed, use separate paper)

FULL NAME	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH

Note: Dependents may be covered only if they were covered under the Plan when your coverage terminated.

I certify that all statements are true and complete to best of my knowledge and belief. I understand false statements or incomplete answers may cause employee and/or dependent continuation coverage to be terminated. I understand it is my responsibility, and that of each person named in this application for continuation coverage, to immediately notify Fund if any information provided on this form changes for any reason. I will notify Fund if any person listed above that is continuing coverage under COBRA with this Plan becomes eligible for other group medical insurance coverage or Medicare during course of COBRA continuation period.

DATE:	QUALIFIED BENEFICIARY:
DATE:	QUALIFIED BENEFICIARY:

Note: If person electing to continue coverage is the Employee, the Employee must sign above. If person electing to continue coverage is a Dependent Spouse, the Dependent Spouse must sign above. If the continuation coverage is for dependent children only, the Employee and the Dependent Spouse must sign above.)