MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND

COBRA Continuation Coverage Election Form

INSTRUCTIONS: To elect continuation coverage, complete this Election Form and return it to us. 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 completed Election Form to: Administrative Manager, Milwaukee Drivers Health and Welfare Trust Fund, 10020 West Greenfield Avenue, Milwaukee, Wisconsin 53214.

This Election Form must be completed and returned by mail or you may hand-deliver it to the Fund Office. If mailed, it must be post-marked by _____.

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

Check either Item A or B below and sign and date this Election Form where applicable.

☐ **A.** I **decline** COBRA continuation coverage. _____
Print Name

_____ _____/_____/_____
Signature Date

☐ **B.** I **elect** COBRA continuation coverage. _____
Print Name

_____ _____/_____/_____
Signature Date

List the individuals in your family for whom you are electing COBRA continuation coverage, including yourself.

Name	*Date of Birth*	*Social Security Number*	*Relationship to Member*