

THE UNITED STATES LIFE Insurance Company  
A **USLIFE** COMPANY

ACKNOWLEDGEMENT/ELECTION OF COBRA CONTINUATION RIGHT

EMPLOYER'S NAME: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

GROUP POLICY NO.: G- \_\_\_\_\_

	Name	DOB	Social Security #
<input type="checkbox"/> Employee	_____	_____	_____
<input type="checkbox"/> Spouse	_____	_____	_____
<input type="checkbox"/> Dependent Child	_____	_____	_____

QUALIFYING EVENT:

- Date Employment Ended: \_\_\_\_\_  
month/day/year
- Date Employee Elected Medicare Primary: \_\_\_\_\_  
month/day/year
- Date Employee Died: \_\_\_\_\_  
month/day/year
- Date of Divorce: \_\_\_\_\_  
month/day/year
- Date Child Ceases To Be Eligible: \_\_\_\_\_  
month/day/year

1. ELECTION/REFUSAL

A) To be completed by the employee:

- I wish to continue my employee health insurance;       I do not wish to continue my employee health insurance.
- I wish to continue health insurance for my spouse;       I do not wish to continue health insurance for my spouse.
- I wish to continue health insurance for my child(ren);       I do not wish to continue health insurance for my child(ren).

B) To be completed by spouse/dependent child.

- SPOUSE:       I wish to continue my health insurance;       I do not wish to continue my health insurance.
- CHILD:       I wish to continue my health insurance;       I do not wish to continue my health insurance.

Note: If you elect to continue insurance, you must complete the INSURANCE TO BE CONTINUED section below.

2. INSURANCE TO BE CONTINUED:

You may elect any combination shown below, but you can only continue insurance that was previously in force.

Employee:	<input type="checkbox"/> Major Medical Benefits	<input type="checkbox"/> Prescribed Drug Benefits	<input type="checkbox"/> Dental Benefits
Spouse:	<input type="checkbox"/> Major Medical Benefits	<input type="checkbox"/> Prescribed Drug Benefits	<input type="checkbox"/> Dental Benefits
Dependent Child(ren):	<input type="checkbox"/> Major Medical Benefits	<input type="checkbox"/> Prescribed Drug Benefits	<input type="checkbox"/> Dental Benefits

3. ACKNOWLEDGEMENT/SIGNATURE

- I acknowledge that I have received and read the attached notice that explains the COBRA rights of continuation.
- I understand that if I elect to continue insurance, the payment of premium for it is my sole responsibility. I further understand that if premium is not received within 31 days of my premium due date, my insurance will automatically end as of the last day of the period for which premium was paid.

\_\_\_\_\_  
EMPLOYEE SIGNATURE / DATE SIGNED

\_\_\_\_\_  
CHILD SIGNATURE (FOR CHILD AGE 18 OR MORE)\* / DATE SIGNED

\* EMPLOYEE SHOULD SIGN FOR A MINOR CHILD

\_\_\_\_\_  
SPOUSE SIGNATURE / DATE SIGNED

RETURN THIS FORM TO THE EMPLOYER AT THE ADDRESS SHOWN ABOVE.