ELECTION FORM

I have read the provisions of the Health Insurance Continuation Rights as provided by Illinois Law. My circumstances are as follows:

- ❑ I have been advised of my rights and I do not elect to continue my coverage.
- ❑ I am a former employee and wish to continue my coverage under my employer's group coverage for a maximum of 12 months. My coverage would otherwise terminate because:
  - ❑ Reduction or work hours
  - ❑ Lay-off
  - ❑ Discharge
  - ❑ Other (describe)

I understand that I am obligated to pay the full cost of my coverage to my employer including the amount normally paid in my behalf by my employer. My dependents can also be covered if they were covered before the qualifying event.

I am electing continuation coverage for:

- ❑ Myself (employee)
- ❑ Spouse
- ❑ Child/Children

- ❑ I am a dependent covered under a plan providing insurance, and I wish to be covered as an insured for a maximum of 24 months or, if age 55 and older, until eligible for Medicare because of:
  - ❑ Separation or divorce
  - ❑ Medicare ineligible spouse and/or child of a Medicare covered worker
  - ❑ Dependent child losing coverage because of attaining the limiting age
  - ❑ Other (describe)

I am electing continuation coverage for:

- ❑ Spouse
- ❑ Child/Children

I understand that I am obligated to pay the full cost of my coverage to my employer including the amount normally paid in my behalf by my employer.

Signed:

_____

Name (Print): _____ Date: _____

Group Number: _____ Employee Number: _____