EMPLOYERS MANAGED HEALTH CARE TRUST OF CALIFORNIA

COBRA Continuation Coverage Election Form

(Note: For individuals not currently on COBRA)

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage and the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance and the additional COBRA election period under the ARP.

Send completed Election Form to:

Employers Managed Health Care Trust Fund
c/o DMC Insurance Administrators, Inc.
P.O. Box 757
Pleasanton, CA 94566
Phone: (925) 426-3555 Fax: (925) 426-3565

This Election Form must be completed and returned by mail. It must be post-marked no later than [*enter date*].

If you don't submit a completed Election Form by the due date shown above, you may 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 submit a completed Election Form before the due date.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the Employers Managed Health Care Trust Fund (the Plan) listed below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)

I (We) certify that I (We) am NOT eligible for coverage under Medicare nor any other group health plan, such as a plan sponsored by a new employer or a spouse's employer.

_____ _____
Signature Date

_____ _____
Print Name Cell Phone

_____ _____
Street Address Relationship to Individual(s) listed above

_____
City, State, Zip Code