



**FOR THE SPOUSE/ELIGIBLE DEPENDENT CHILDREN**

(This form must be completed if the Employee declined coverage and the Spouse wishes to continue or to decline coverage for himself/herself and/or eligible dependent children. This form can be completed by an eligible dependent if neither the employee nor spouse has elected COBRA continuation coverage for the eligible dependent.)

I elect COBRA continuation coverage for the following qualified beneficiaries who had coverage on the group health plan before the qualifying event:

Active Medical

Active Medical/Dental/Vision

Non-Medicare Retiree Medical & Rx

Medicare Retiree Medical & Rx

Spouse \_\_\_\_\_

Social Security # \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

(Please list additional dependents below)

I hereby DECLINE COBRA continuation coverage under the group health plan

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

**FOR NON-ELIGIBLE DEPENDENTS (age 18 and over)**

(This form must be completed by each dependent age 18 and over if the dependent is no longer eligible for coverage as a dependent.)

I elect COBRA continuation coverage under the group health plan

Active Medical

Active Medical/Dental/Vision

I hereby DECLINE COBRA continuation coverage under the group health plan

\_\_\_\_\_  
Dependent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security No.

Additional Dependents:

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dependent \_\_\_\_\_

Date of Birth \_\_\_\_\_