



**IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST  
Employee/Dependent COBRA Election Form**

Date \_\_\_\_\_

As explained in the letter accompanying this form, to elect COBRA continuation coverage, this form must be completed, signed and received by Iron Workers District Council of Southern Ohio & Vicinity within 60 days from the later of the date of the letter or termination of coverage. If you do not submit a completed Election Form by that date, you will 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 furnish a new 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. Read the important information about your rights included in the pages after the Election Form. When you are terminated (except for gross misconduct), your hours are reduced, or you retire, you may elect coverage for up to 18 months for yourself and your dependents.

This Plan will allow you to choose continuation of either health benefits only or health benefits with dental and vision coverage. The rates in effect as of the date of this election are:

- Active Basic COBRA Health Coverage (single or family):** **\$689.45 per month**
- Active Basic COBRA Health/Dental/Vision Coverage (single or family):** **\$732.03 per month**
- Non-Medicare Retiree COBRA Medical & Rx Coverage (per person):** **\$657.00 per month**
- Medicare Retiree COBRA Medical & Rx Coverage (per person):** **\$384.00 per month**

Please be aware that these rates are subject to change due to either the benefits provided or the expiration of the current rates in effect. At that time, you will be notified of any rate changes and the reason for the change.

Please send completed election form to: **Iron Workers District Council of Southern Ohio & Vicinity**  
**Attn: COBRA**  
**Main P.O. Box 398**  
**Dayton, Ohio 45401-0398**

I (We) elect COBRA continuation coverage in the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust as indicated below:

**Are you or any person to be covered insured by any other group health plan, Medicare, Medicaid or Champus/Tri-Care?**  Yes \_\_\_\_\_  No \_\_\_\_\_

	Name of Plan	Policy Number
<input type="checkbox"/> No		

**FOR THE EMPLOYEE**

- 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

Employee _____	Subscriber ID _____
Spouse _____	Date of Birth _____
Dependent _____	Date of Birth _____
Dependent _____	Date of Birth _____
Dependent _____	Date of Birth _____

(Please list additional dependents on second page)

I hereby DECLINE COBRA continuation coverage under the group health plan

\_\_\_\_\_

Employee Signature

Date

(1)

**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
  - Non-Medicare Retiree Medical & Rx
  - Active Medical/Dental/Vision
  - Medicare Retiree Medical & Rx

Spouse \_\_\_\_\_

SS# \_\_\_\_\_

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 \_\_\_\_\_

(2)