MICHIGAN CARPENTERS' HEALTH CARE FUND

COBRA Election Form

(FORM MUST BE RETURNED WITH PAYMENT)

I, _____, wish to continue coverage under the Plan. I have read and understood the provisions for continuing such coverage.

It is the intent of the Board of Trustees to review these rates and make appropriate adjustments periodically.

Are you currently covered by another group health care plan?
Yes _☐_ No _☐_

If yes, indicate name of plan _____

Are you currently eligible for Medicare Benefits?
Yes _☐_ No _☐_

_☐_ Health Care & Vision Benefits (No Death Benefits included) **$753.13** per month
To include **Dental** Benefits add an additional
_☐_ **$8.51** for Single member
_☐_ **$17.02** for 2 member family
_☐_ **$25.53** for 3+ member family
_☐_ **NO** dental coverage

_____ _____
Signature of Participant Date

_____ _____
Name of Participant (printed) BCBS ID Number

List Individuals to be covered:

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

---------- **FOR OFFICE USE ONLY:** ----------

CODE _____ RATE _____ BD _____ TD _____ LENGTH