

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 Benefits **ONLY** (No Death Benefits included) \$627.65 per month

Yes _____ No _____

Signature of Participant

Date

Participant's Name

Amount Enclosed

Member Identification Number

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

CODE _____ RATE _____ BD _____ TD _____ LENGTH _____