ELECTION FORM
COBRA CONTINUATION COVERAGE
Sign Pictorial & Display Industry Welfare Fund

I HAVE READ THIS FORM AND THE NOTICE OF RIGHTS ACCOMPANYING THIS FORM, AND I UNDERSTAND MY RIGHT TO ELECT CONTINUATION COVERAGE INDICATED BELOW.

I UNDERSTAND THAT IF I FAIL TO PAY ANY PREMIUM PAYMENT ON TIME, MY COVERAGE WILL TERMINATE. I ALSO UNDERSTAND THAT MY COVERAGE MAY TERMINATE FOR ANY OF THE REASONS LISTED IN THE TERMINATION OF COBRA CONTINUATION COVERAGE SECTION.

I AGREE TO KEEP THE ADMINISTRATION OFFICE INFORMED OF ANY CHANGES OF ADDRESS AND/OR FAMILY MEMBERS. I ALSO AGREE TO NOTIFY THE ADMINISTRATION OFFICE IF I OR ANY OTHER QUALIFIED BENEFICIARIES BECOME COVERED BY ANOTHER GROUP HEALTH PLAN OR MEDICARE.

Please check the appropriate **Qualifying Event** which has caused the loss of your health coverage:

- ☐ Termination of employment, reduction in hours, voluntary quit or layoff
- ☐ Death of member
- ☐ Divorce
- ☐ Medicare eligibility of the member
- ☐ Dependent child exceeds Plan’s age limit
- ☐ Military Service

Please check the type of continued coverage you elect to have (ONE only):

- ☐ I elect to continue medical, dental & vision coverage under the Plan at the current benefit level (life and accidental death & dismemberment benefits are not included).
- ☐ I elect to continue coverage under the Plan for core medical benefits only (no Dental, no Vision).

______________________________ *Signature*

______________________________ *Date*

Member Information

LAST NAME		FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)				SEX	DATE OF BIRTH
CITY	STATE/ZIP	TELEPHONE NUMBER ( )		EMAIL ADDRESS	

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DEPENDENTS TO BE COVERED UNDER COBRA

Please list your eligible dependents to be covered under COBRA. If you have children who were also dependents of the Participant and who have lost coverage, you must provide the following information and a birth certificate (if applicable) for each of them.

Dependent Information

DEPENDENT'S NAME	RELATIONSHIP TO PARTICIPANT*	SEX	DATE OF BIRTH			SOCIAL SECURITY NUMBER

*Relationship: Spouse, Child, Stepchild.

IMPORTANT NOTICE: If you acquire a child after you have begun coverage under COBRA, you may cover that child under this plan. Contact the Administration Office if you acquire a child while on COBRA coverage.

Please send the completed Election Form to:

Allied Administrators
P.O. Box 2500
San Francisco, CA 94126