

ACKNOWLEDGEMENT OF RECEIPT OF COBRA RIGHTS

I hereby acknowledge that I have received notice of rights to continue health plan coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

I understand that I (and/or my spouse and dependent children) **must complete and submit the attached COBRA Election Form within 60 days of (1) the date of this notice or (2) the loss of coverage (whichever is later)** in order to be considered for continuation of coverage. I further understand that all costs of continuation coverage will be at my expense.

Signature

Date

Print Name

If any of the individuals entitled to coverage under your plan do not reside at your address, please list those individuals and their current address(es) below so they may receive notification of their COBRA rights as soon as possible. Attach a separate page with additional names and addresses if necessary.

Name

Address

City

State

Zip

Name

Address

City

State

Zip

Direct questions and return this form to:

Representative

Company Name

Address
