COBRA CONTINUATION COVERAGE ELECTION FORM
NTC

IMPORTANT: PLEASE RETAIN A COPY OF THIS COBRA ELECTION FORM FOR FUTURE REFERENCE. THIS FORM CONTAINS INFORMATION ABOUT YOUR RIGHTS UNDER COBRA.

To continue coverage, you must complete and submit this election form to Discovery Benefits, Inc. TEST no later than the Election Period End date ("Last Day To Elect") listed below. If this election form is not returned within the enrollment period described below for each plan, you will lose your right to elect coverage. After you have elected to continue coverage under COBRA, you must pay the initial premium, which includes the period of coverage from your First Day of COBRA to the date of your election and any regularly scheduled monthly premiums that become due between your election date and the end of the initial premium payment period. The initial premium payment grace period will end after your election to continue coverage.

If you have questions about COBRA or need assistance to complete your election form, please contact our Customer Service Department at (866) 451-3399 during business hours.

Qualified Beneficiary(QB):

Sally Martin
123 25th St. S
Fargo, ND 58103

Event Date: 5/31/2014
Event Type: Loss of Eligibility
Second Event: No

COBRA gives you the right to elect coverage independently. You, your spouse or dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage.

Premium Information:

Plan Name	Coverage Level	Monthly Premium
1 Medical	QB Only	$255.00
	Total Premium:	$255.00

Plan Name	First Day of COBRA	Last Day of COBRA	# Months of COBRA	Last Day To Elect	Initial Grace Period Days	Subsequent Grace Period Days
1 Medical	6/1/2014	11/30/2015	18	8/25/2014	45	30

Please list each of the individuals electing continuation (including yourself, if applicable) along with their social security number, date of birth and gender.

Qualified Beneficiary SSN Date of Birth Gender
1._____
2._____
3._____
4._____
5._____

Election Options (Individuals Enrolled Prior to Qualifying Event):
Please indicate the COBRA continuation coverage you are electing by checking the applicable box(es).

Name	Relationship	Date of Birth	SSN
Sally Martin	QB	10/21/1987	xxx-xx-5555

Accept ☐ Waive ☐ 1 Medical

All correspondence and premium payments should be remitted directly to the address below. Payment must be in the form of a check or money order. DO NOT send cash.

Discovery Benefits, Inc. TEST
PO Box 2079
Omaha, NE 68103-2079

[ ] I have read this form and the notice of my election rights. I understand my rights to elect continuation coverage and would like to take the action indicated above. I understand that if I elect continuation coverage, my continuation coverage will terminate under several circumstances according to COBRA regulations, including: non-payment of premium, the date I or a continued dependent become covered under another Group Health Plan or become entitled to Medicare after the COBRA election, or on the date which this Group Plan ends. I also understand that if I was determined to be disabled by the Social Security Administration within 60 days of my Qualifying Event, I may be eligible for extended continuation coverage and that any break in continued coverage of more than 63 days may cause loss of coverage portability.

I understand that future premiums are due the first of each month. I also understand that failure to pay the required premiums will result in termination of COBRA rights and coverage.

Signature _____ **Date** _____

*NOTE: If signature line is on a second page, be sure to include all pages of the election form. We will not be able to process your election without the entire form.