ELECTION FORM
LABORERS' METROPOLITAN DETROIT HEALTH CARE FUND

I have read and understood the provisions for continuing coverage. I have checked the type of coverage elected below. I understand that, once a type of coverage is elected, it may not be changed at a later date. I also understand that no Death Benefits of any type are provided with either type of COBRA Continuation Coverage.

(It is the intent of the Board of Trustees to periodically review the self-payment rates and make appropriate adjustments). The rates reflected on this form are effective as of October 1, 2011.

Are you or any of your dependents currently covered by another group health care plan?

☐ YES ☐ NO

If YES, indicate name of plan:_____

If YES, list names of dependents covered by other plan(s):_____

Are you or any of your dependents currently eligible for Medicare benefits?

☐ YES ☐ NO

COBRA CONTINUATION COVERAGE:

☐ Health Care Benefits **ONLY**, at the rate of $812.85 per month for 18 consecutive months when loss of coverage results from unemployment. (NO DEATH BENEFITS INCLUDED IN THIS COVERAGE)

☐ Health Care, Dental, and Vision Benefits, at the rate of $903.69 per month for 18 consecutive months when loss of coverage results from unemployment. (NO DEATH BENEFITS INCLUDED IN THIS COVERAGE).

ALTERNATIVE COVERAGE:

☐ Health Care, Dental, and Vision, and Death Benefits, at a rate of $399.42 per month for the first 12 months and $543.72 for the last 6 months for a total of 18 consecutive months, (**TO BE ELIGIBLE FOR ALTERNATIVE COVERAGE, PARTICIPANT MUST BE UNEMPLOYED AND MUST BE AVAILABLE FOR WORK WITHIN THE JURISDICTION OF THE FUND).**

☐ I decline coverage for myself and/or my dependents under either COBRA Continuation Coverage or Alternative Coverage.

_____

Participant's Name (Please Print) Social Security Number

_____

Participant's Signature Date Signed

_____

Spouse's Signature Social Security Number Amount Enclosed

PLEASE LIST INDIVIDUALS TO BE COVERED

NAME	RELATIONSHIP	DATE OF BIRTH