COBRA Continuation Waiver of Coverage Form

Date

☐ Mailed ☐ Hand-delivered

Qualified Beneficiary Information

First Name	M.I.	Last Name	Social Security Number
			- -

Street Address

City	State	Zip Code

Policy Number	Marital Status	Number of Dependents

Entitlement to COBRA Coverage

Your health care coverage under your group health plan will cease on [insert date] because of the following:

☐ Termination of employment ☐ Reduction in hours of employment

According to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this is a qualifying event that may entitle you (and your spouse and dependent children, if any) to elect to continue coverage under the plan for up to 18 months from the date of your qualifying event.

Waiver of COBRA Coverage

You may also be entitled to a different level of benefits under the Company's alternative coverage, which may be explained in a separate notice. This notice constitutes your decision to waive your COBRA rights in favor of the alternative coverage. Please complete the form below to make this waiver effective.

Waiver of Coverage

I have read these explanations and understand the rights that apply under COBRA coverage and the alternative coverage. I hereby elect to be covered under the company's alternative coverage and waive continuation coverage under COBRA. I understand that in making this election, group health coverage will terminate on [insert date] or, if earlier, the date of the termination of employment or failure to pay the premium on time. I also understand that once this alternative coverage ends, I will not have any continuation coverage rights under COBRA. I understand that my spouse and/or dependent children may have additional COBRA rights if I die, become entitled to Medicare, incur a divorce or legal separation or have a dependent who ceases to be a dependent under the plan.

Print Name	Signature	Relationship	Date

This waiver is effective on [insert date]. It may be revoked in writing at any time before that date.

For Internal Use Only

Received by Plan Administrator (initials):

Date:

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