

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200
P.O. BOX 4000, BURLINGTON, MASSACHUSETTS 01803-0900
TELEPHONE (781) 272-1000 FAX (781) 272-2226 (800) 342-3792

COBRA CONTINUATION ELECTION FORM

All information on this form must be completed by each person electing to continue coverage for member, spouse, or eligible dependents, and returned to the Fund Office by the date indicated on the "notice of the right to continue coverage" letter.

Are you presently on Medicare, or any other health insurance? _____ Yes _____ No

Is your spouse or dependent presently on Medicare, or any other health insurance? _____ Yes _____ No

Type of Coverage: (Check One Only)

Plan I-CORE

Medical, surgical, hospital, hearing and prescription benefit

Individual Family

Plan II-CORE and DENTAL

All of the above plus dental benefits

Plan III-CORE and DENTAL and VISION

All of the above plus vision benefits

Member's Name: _____
(Please Print)

Local Union #: _____

Soc. Sec. #: _____

Date of Birth: _____

Spouse's or Dependent's Name: _____
(Please Print)

Spouse or dependent to complete only if both selected individual plans

Soc. Sec. #: _____

Date of Birth: _____

Address: (Premium notice will be sent to this address.)

Tel. #: () _____ - _____

Street: _____

City/Town, State, Zip Code: _____

Signature of Member: _____ Date: _____

Signature of Spouse or Dependent: _____ Date: _____

****INCOMPLETE FORMS WILL BE RETURNED****