

**MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND**

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200

BURLINGTON, MASSACHUSETTS 01803-5201

TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX 781-238-0703

**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  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

**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

Individual		Family	
Plan A	Plan B	Plan A	Plan B
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(In order to continue uninterrupted coverage, you are strongly urged to enclose 2 months of Premium payment with this form.)

Member's Name: \_\_\_\_\_ Local Union #: \_\_\_\_\_  
(Please Print)

Soc. Sec. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's or Dependent's Name: \_\_\_\_\_ Spouse or dependent to complete only if  
(Please Print) 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\*\***