**MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND**

P.O. BOX 1501 • 1400 DISTRICT AVENUE, SUITE 200
BURLINGTON, MASSACHUSETTS 01803-9005
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 later of 60 days from the date on the enclosed election notice or 60 days from the date you will lose coverage.

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)

| | Individual | | Family | |
|---|---|---|---|---|
| | **Plan A** | **Plan B** | **Plan A** | **Plan B** |
| **Plan I-CORE**<br>Medical, surgical, hospital, hearing and prescription benefit | _____ | _____ | _____ | _____ |
| **Plan II-CORE and DENTAL**<br>All of the above plus dental benefits | _____ | _____ | _____ | _____ |
| **Plan III-CORE and DENTAL and VISION**<br>All of the above plus vision benefits | _____ | _____ | _____ | _____ |

**(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 both selected individual plans**
(Please Print)

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****