

Date \_\_\_\_\_

[Employer's Name and Address]

Dear Human Resources,

I hereby elect/waive the following for COBRA continuation coverage:

**[Medical Carrier Name]**

	<b>HMO</b>	<b>Elect</b>	<b>Waive</b>	<b>PPO</b>	<b>Elect</b>	<b>Waive</b>
<b>Employee Only</b>		_____	_____		_____	_____
<b>Employee +1</b>		_____	_____		_____	_____
<b>Employee +2</b>		_____	_____		_____	_____

**[Dental Carrier Name]**

	<b>DMO</b>	<b>Elect</b>	<b>Waive</b>	<b>DPO</b>	<b>Elect</b>	<b>Waive</b>
<b>Employee Only</b>		_____	_____		_____	_____
<b>Employee +1</b>		_____	_____		_____	_____
<b>Employee +2</b>		_____	_____		_____	_____

**[Vision Carrier Name]**

	<b>Elect</b>	<b>Waive</b>
<b>Employee Only</b>	_____	_____
<b>Employee +family</b>	_____	_____

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Note: the COBRA amount is due by the 1<sup>st</sup> of each month. Checks can be made payable to [Employer's Name]. Please send to Attn: Human Resources, [Employer's Address].