COBRA Continuation Coverage Election Form

Important: This form must be completed and returned by mail. It must be post-marked no later than________. Send completed form to:

Building Trades Health & Welfare Fund
1718 Heilmandale Road, Suite 400
Lebanon, PA 17046

I (We) elect to continue our coverage in the Building Trades Health & Welfare Fund (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. ____

b. ____

c. ____

d. ____

Type of coverage elected (check only one):

☐ I wish to continue my benefits under the Plan on the following basis:

☐ Individual
☐ Two Party
☐ Family

☐ I do not wish to continue benefits under the Building Trades Health & Welfare Fund.

☐ I do not wish to continue my dependents' benefits under the Building Trades Health & Welfare Fund.

_____________________________________ _____________________________
Signature Date

_____________________________________ _____________________________
Print Name Relationship to individual(s) listed above

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_____________________________________ _____________________________
Print Address Telephone number