GUARDIAN® The Guardian Life Insurance Company of America

Election of COBRA Continued Coverage

Planholder Name	Group Plan #	Date

Planholder Address

Name of Insured Employee (Last, First, MI)	☐ M ☐ F	Social Security #	Date of Birth	Class

Names of Continuing Eligible Dependents (If more space is needed please attach a separate sheet of paper)

Full Name (Last, First, MI)	Social Security #	Sex	Date of Birth	Relationship to Employee
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		

Home Address:

Reason for Loss of Coverage *(Check one)*

☐ Termination of Employment ☐ Legal Separation ☐ Child Losing Dependent Status

☐ Reduction of Work Hours ☐ Divorce ☐ Death of Employee

Date Coverage Will Terminate Due to Qualifying Event

For Guardian Use Only

Explanation *(If necessary)*

THIS NOTICE CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHT TO CONTINUE YOUR HEALTH CARE COVERAGE.
Please read the information contained in this notice very carefully.

Federal law permits continuation of Medical, Dental, Vision and stand alone Prescription Drug coverage for certain qualifying events. Each person ("qualified beneficiary") who has one of the qualifying events listed in the chart below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for the period of time listed in the corresponding coverage period. An individual's Life, Accidental Death and Dismemberment and Disability Income insurance may not be continued.

Qualifying Events	Qualified Beneficiary	Coverage Period
Termination (other than gross misconduct)	Employee, Spouse, Dependent Child	18 months
Reduced Hours	Employee, Spouse, Dependent Child	18 months
Employee Enrolled in Medicare	Spouse, Dependent Child	36 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of covered employee	Spouse, Dependent Child	36 months
Loss of "dependent child" status	Dependent Child	36 months

Note:
An individual who is determined to be totally disabled under the Social Security Act at any time during the first 60 days of continued coverage, or a family member of the individual, may extend coverage from 18 to 29 months if the determination is provided before the end of the 18 month period. When it is determined under the Social Security Act that the individual is no longer disabled, continuation beyond 18 months will end in the month that begins more than 30 days after the determination.

COBRA continuation will cost: _____. You do not have to send any payment with this Election Form. Important additional information about payment for COBRA continuation coverage is included in a packet of information, which is included in the pages following this election form.

NOTE: This is an election form only. It is not intended to constitute complete notice of your COBRA continuation rights. If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact your employer/plan administrator.

Instructions:

To elect COBRA continuation coverage, complete this Election Form and return it to your employer/plan administrator. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan. This election form must be completed and returned to your employer/plan administrator within 60 days of notification.

If you do not submit a completed Election Form to your employer/plan administrator within 60 days of notification, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

PLEASE READ THE CERTIFICATE BOOKLET FOR ADDITIONAL INFORMATION

☐ I do not elect to continue my medical/dental/vision/prescription drug coverage under the Group Plan.

☐ I elect to continue my medical/dental/vision/ prescription drug coverage under the Group Plan and agree to the conditions and requirements outlined above. *(Note: In most instances Medicare benefits will be primary for individuals entitled to COBRA.)*

Please continue coverage for:

☐ Employee:	☐ Major Medical	☐ Dental	☐ Vision	☐ Stand Alone RX
☐ Employee & Eligible Dependents:	☐ Major Medical	☐ Dental	☐ Vision	☐ Stand Alone RX
☐ Spouse:	☐ Major Medical	☐ Dental	☐ Vision	☐ Stand Alone RX
☐ Spouse & Child(ren):	☐ Major Medical	☐ Dental	☐ Vision	☐ Stand Alone RX
☐ Child(ren):	☐ Major Medical	☐ Dental	☐ Vision	☐ Stand Alone RX

You must advise the planholder, in writing, in the event you are no longer eligible for continuation or you no longer wish to continue coverage.

Signature of Person Electing/Refusing Continuation	Date
Certified for Planholder By (Name and Title)	Date

KEEP A COPY FOR YOUR RECORDS AND SEND A COPY TO THE PERSON MAKING THE ELECTION.