EXTREMELY IMPORTANT!!!!!
PLEASE COMPLETE,SIGN & RETURN IF YOU WANT CONTINUED COVERAGE

Name of Union Member I.D.#

PLUMBING AND PIPEFITTING INDUSTRY
HEALTH AND WELFARE FUND OF KANSAS

ELECTION FORM FOR CONTINUED COVERAGE UNDER COBRA SELF-PAY

Name

Address

City State Zip Code

Phone # Social Security #

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Application and return it to us. 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 form must be completed and returned by mail or in person. If mailed, it must be post-marked no later than _____. Send completed form to:

Plumbing and Pipefitting Industry
Health and Welfare Fund of Kansas
505 S. Broadway, Ste. 117
Wichita, KS 67202-3922
(316) 264-2339

If you do not submit a completed Election Form by the due date shown above, 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 submit 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 submit the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

(The name of the person applying for continued coverage should be entered on the top line. If more than one family member is applying for continued coverage, enter the name of the employee, {or if the employee is not applying for continued coverage, the name of the employee's spouse}).

Date coverage could terminate OR CHANGE TO COBRA SELF-PAY: _____
(Date represents Cobra start date if partial payment is made, otherwise, Cobra start date will be 1 month earlier)

I desire to continue the following coverage under the Plan sponsored by the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas. I understand that I am responsible for the full payment of the monthly charge. That monthly amount is set forth on the "Notice of Termination of Coverage," which I have received. Payments must be made retroactive to the date on which coverage would otherwise terminate.

Coverage to be continued for: (check no more than one type of coverage per person)

☐ SINGLE COVERAGE ☐ FAMILY COVERAGE

Employee - Name: _____ SSN: _____

DATE OF BIRTH: _____

Spouse - Name: _____ SSN: _____

DATE OF BIRTH: _____

Child - Name: _____ SSN: _____

DATE OF BIRTH: _____

Child - Name: _____ SSN: _____

DATE OF BIRTH: _____

Child - Name: _____ SSN: _____

DATE OF BIRTH: _____

Child - Name: _____ SSN: _____

DATE OF BIRTH: _____

Child - Name: _____ SSN: _____

DATE OF BIRTH: _____

Child - Name: _____ SSN: _____

DATE OF BIRTH: _____

Note: If continued coverage is requested for more than six dependent children, please ask for and complete an additional Election Form.

I understand that the appropriate monthly payments must be mailed to the Fund Office, by the first day of each month for which coverage is to be provided. **I FURTHER UNDERSTAND THAT COVERAGE ON ANY OF THE ABOVE INDIVIDUALS IS SUBJECT TO AUTOMATIC TERMINATION UNDER ANY OF THE CIRCUMSTANCES DESCRIBED ON PAGE FOUR OF THE NOTICE OF TERMINATION OF COVERAGE.**

Signature of Applicant: _____

Date: _____

IMPORTANT INFORMATION ABOUT PAYMENT

First payment for continuation coverage
You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is set forth on the "Notice of Termination of Coverage," which has been provided to you. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month for which coverage is to be provided. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.