ELECTION FORM
MICHIGAN LABORERS' HEALTH CARE FUND

I have read and understood the provisions for continuing coverage. I have checked the type of coverage desired below. **I understand that once a type of coverage is elected it may not be changed at a later date.** I also understand that no Death or Loss of Time Benefits of any type are provided by either type of COBRA CONTINUATION COVERAGE.

THIS FORM MUST BE COMPLETED AND RETURNED IN ORDER TO BE ELIGIBLE FOR COVERAGE

It is the intent of the Board of Trustees to review these rates and make appropriate adjustments on a regular basis.

Are you or any of your dependents currently covered by another group health care plan? ☐ Yes ☐ No

If yes, list names of dependents covered by other plan_____

_____

If yes, indicate name of plan_____

Are you or any of your dependents currently eligible for Medicare Benefits? ☐ Yes ☐ No

ALTERNATIVE COVERAGE:
(Alternative Coverage is limited to 24 consecutive self-payments)

☐ Health Care **ONLY** (including Death and Loss of Time Benefits) at a rate of $482.32 per month for the first 12 months and $747.52 per month for the second 12 months. (Retirees, please contact the Fund Office).

COBRA CONTINUATION COVERAGE:
(COBRA Coverage is limited to 18 consecutive self-payments)

☐ Health Care Benefits **ONLY** at the rate of $620.43 per month.

_____

Signature of Participant — Member ID or Social Security #

_____

Spouse's Signature — Amount Enclosed

_____

Participant's Name — Date Signed

List individuals to be covered (use reverse side, if necessary):

Name	Relationship	Date of Birth
_____	SELF	_____
_____	SPOUSE	_____
_____	_____	_____