

COBRA Election of Continuation of Coverage

Date: _____

Name: _____

Health Insurance Subscriber Name: _____

You have the right to elect continuation coverage under COBRA. Please complete this election form and return it to Jenn Delehanty at the District Office. If you are continuing coverage you will be sent an application form at that time. If you have any questions, please call or email Jenn Delehanty at 315-589-9661, jdelehanty2@williamsoncentral.org.

WAIVER OF CONTINUATION COVERAGE UNDER COBRA

[] I have been advised of my rights under COBRA and I elect **not** to continue my coverage. I understand, however, that I may revoke this waiver and elect to participate at any time during the 60 day election period described in the attached notification letter, although coverage need not be provided before the date of my revocation of this waiver.

Signature _____ Date _____

ELECTION OF CONTINUATION COVERAGE UNDER COBRA

[] I elect to continue to participate in Williamson Central School's health insurance plan under COBRA. I understand that I am obligated to pay the full cost of my coverage, plus an additional administrative charge, and, if coverage is extended up to 29 months due to my disability, that the charge will equal 50% of the normal premium after the eighteenth month of coverage.

Signature _____ Date _____

COBRA BILLING ADMINISTRATION

If you elect coverage under COBRA, Excellus BlueCross BlueShield will act as the Williamson Central School's billing agent and will bill you directly on a monthly basis. They will notify you as to where and when you pay your bill.