MICHIGAN LABORERS' HEALTH CARE FUND
ELECTION FORM

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 either type of COBRA CONTINUATION COVERAGE provides no Death or Loss of Time Benefits of any type.

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)

1. ______Health Care **(including** Death and Loss of Time Benefits as well as Dental and Vision Coverage) at rate of $552.72 per month for the first 12 months and $856.62 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)

COBRA CONTINUATION COVERAGE: Member only/Single Person Coverage
2.______ Health Care Benefits **ONLY** at the rate of **$422.89 per month**
3.______Health Care, Dental, and Vision Benefits for the Member only at the rate of **$442.04 per month**

COBRA CONTINUATION COVERAGE: Two Person Coverage
4. ______Health Care Benefits **ONLY** at the rate of **$1014.93 per month**
5. ______ Health Care, Dental, and Vision Benefits for Two Person Coverage at the rate of **$1053.23 per month**

COBRA CONTINUATION COVERAGE: Family Coverage
6. ______ Health Care Benefits **ONLY** at the rate of **$1268.66 per month**
7.______ Health Care, Dental, and Vision Benefits for Family Coverage at the rate of **$1334.99 per month**

____
Participant's Name (Please Print) Date Signed

____
Signature of Participant Member Id or SS#

____
Telephone Number (Including Area Code) Amount Enclosed

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

Name	Relationship	Date of Birth	Social Security Number
____________	SELF	________	____________
____________	SPOUSE	________	____________
____________	______	________	____________
____________	______	________	____________
____________	______	________	____________
____________	______	________	____________