COBRA RIGHTS ACKNOWLEDGEMENT

I hereby acknowledge that I have received notification of my COBRA continuation rights to extend my group plan health coverage. I understand that all costs for continuation coverage will be at my own expense. I must also submit a COBRA Continuation Election Form to elect for coverage within 60 days of the loss of coverage.

I understand that all costs for continuation coverage will be at my expense, and coverage will only be reinstated once payment is received. I understand my COBRA coverage will automatically terminate once I cease remitting the required monthly payments. **CAHC will not send notices or invoices of payments due**.

Employee Signature: _____ Date: _____

Printed Name: _____

YOUR SPOUSE MUST ALSO SIGN THIS FORM IF ARE MARRIED AND INCLUDING THEM ON THE HEALTH INSURANCE PLAN.

Spouse's Signature: _____ Date: _____

Spouse's Printed Name: _____

Employees and their spouses are responsible for promptly informing CAHC of a divorce, legal separation, or child losing dependent status under the group plan. In addition, employees or family members must keep CAHC informed of their current addresses.

Please return completed form to CAHC by emailing it to cahcgroup@uchc.edu.