Southern California United Food & Commercial Workers Unions and
Food Employers Joint Benefit Funds Administration, LLC
6425 Katella Avenue • P.O. Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 • 877-284-2320
www.scufcwfunds.com

RETIREE PLAN COBRA COVERAGE ELECTION FORM

Election of Coverage - Spouse and Dependent Children Only

I (we) have read the Notice of Qualifying Event for COBRA Continuation Coverage (the "Election Notice"). I (we) elect COBRA coverage under the Fund for the individuals named below.

Please provide the names, Social Security numbers and dates of birth only for the individuals(s) electing COBRA Coverage in the spaces provided below.

- For each individual, indicate whether (s)he is choosing Core Benefits Only or Core Benefits Plus.
- Stepchildren and foster children may be listed only if they have been certified as eligible by the Fund Office.
- If any qualified beneficiary does not reside with the Retiree, you must provide his or her address in the space provided below so
- that we may advise that qualified beneficiary of his or her COBRA rights.
- **Attach additional Dependent information on separate sheet of paper.**

______________________________ ______________________ ______________________
Spouse's Full Name Social Security Number Date of Birth

____
Address (if not residing with Retiree)

____ Core Benefits Only
(Medical, Prescription Drug)

____ Core Benefits Plus
(Medical, Prescription Drug, Dental, Vision)

______________________________ ______________________ ______________________
Dependent's Full Name Social Security Number Date of Birth

____Son ____Daughter
____Stepchild ____Other

____
Address (if not residing with Participant)

____ Core Benefits Only
(Medical, Prescription Drug)

____ Core Benefits Plus
(Medical, Prescription Drug, Dental, Vision)

______________________________ ______________________ ______________________
Dependent's Full Name Social Security Number Date of Birth

____Son ____Daughter
____Stepchild ____Other

____
Address (if not residing with Participant)

____ Core Benefits Only
(Medical, Prescription Drug)

____ Core Benefits Plus
(Medical, Prescription Drug, Dental, Vision)

______________________________ ______________________ ______________________
Dependent's Full Name Social Security Number Date of Birth

____Son ____Daughter
____Stepchild ____Other

____
Address (if not residing with Participant)

____ Core Benefits Only
(Medical, Prescription Drug)

____ Core Benefits Plus
(Medical, Prescription Drug, Dental, Vision)

Instructions for Returning the Election Form
To elect COBRA Coverage, complete this Election Form and mail it to the Fund Office by the Final Election Date shown on the first page of the enclosed Election Notice. Under federal law, you must have 60 days after the later of the date of the Election Notice or your Loss of Eligibility Date (both of which are shown on the first page of the Election Notice) to elect COBRA Coverage under the Fund. **Mail the completed Election Form to: Attention - COBRA, UFCW Unions and Food Employers Benefit Fund, P.O. Box 6010, Cypress, CA 90630.** The Election Form must be post-marked no later than the Final Election Date.

If you do not submit a completed Election Form to the Fund Office within this 60-day period, you will lose your right to elect COBRA Coverage. If you reject COBRA Coverage before the 60-day period expires, you may change your mind as long as you submit a completed Election Form before the Final Election Date. However, if you change your mind after first rejecting COBRA Coverage, your COBRA Coverage will begin on the date you submit the completed Election Form, retroactive to the Qualifying Event Date.

First Payment for COBRA Coverage
The first payment for COBRA Coverage must be received within forty-five (45) days after the date of your election (i.e., the date your Election Form is postmarked). Subsequent payments are due in the Fund Office on the first day of each month and will not be accepted if over 30 days late. Should you fail to make timely payment, your COBRA Coverage will terminate.

Other Coverage Information (check all that apply):

____ Check here if any person electing COBRA Coverage became entitled to Medicare (Part A, Part B, or both) before electing COBRA and provide the name(s) and date(s) of Medicare entitlement here: _____

____ Check here if any person electing COBRA Coverage is currently covered under another group health plan and provide the following information:

_____ Name of individual(s) with other coverage

_____ Employer's address/telephone number

_____ Name of the insurance company or health plan

_____ Group number

Retiree's Information (Please provide the Retiree's information, even though the Retiree is not electing COBRA coverage)

_____ Retiree's Last Name, First Name _____ M.I. _____ Social Security Number: _____ Home Telephone Number

_____ Mailing Address _____ City _____ State _____ Zip Code _____ Work Telephone Number

_____ Former Employer

____ Female ____ Male

____ Never Married ____ Married (date) _____
____ Divorced (final dissolution date) _____
____ Widowed (date) _____

Applicant's Information *(The Applicant is the person filling out this form on behalf of qualified beneficiaries. If the Applicant is the Retiree, complete name only)*

_____ Participant's Last Name _____ First Name _____ M.I. _____ Social Security Number: _____ Home Telephone Number

_____ Mailing Address _____ City _____ State _____ Zip Code _____ Work Telephone Number

_____ Relationship to Participant

____ Female ____ Male

____ Never Married ____ Married (date) _____
____ Divorced (final dissolution date) _____
____ Widowed (date) _____

Applicant's Signature: Sign and Date Your Application Here

- I hereby certify that all information above is true and correct to the best of my knowledge.
- I understand that the Fund Office will not send monthly billings and that failure to pay on a timely basis will terminate COBRA Coverage and COBRA Coverage cannot be reinstated once terminated.
- I will notify the Fund Office in writing within 30 days if any person electing COBRA Coverage becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under another group health plan.

_____ Signature _____ Printed Name _____ Date