LABORERS'
BENEFITS • ST. LOUIS

COBRA ELECTION FORM

I have read and understand the provisions of the Consolidated Omnibus Budget Reconciliation Act (C.O.B.R.A.) Notice provided to me in the "Continuation Coverage Rights" which I have received. I apply for the following COBRA continuation coverage for continuation of medical, prescription, dental, vision and membership assistance program.

Check one category below and circle the rate. The below rates are monthly COBRA rates.

Category	**COBRA Rates Effective 1-1-2026**	**COBRA S.S. Award Disability Rates Effective 1-1-2026**
( ) One Adult	$609	$896
( ) Two Adults	$1,218	$1,792
( ) One Adult & Child	$905	$1,331
( ) One Adult & Children	$1,199	$1,764
( ) Two Adults & Child	$1,514	$2,227
( ) Two Adults & Children	$1,808	$2,660
( ) Child *(Under the age of 26)*	$296	$435
( ) Children *(Under the age of 26)*	$590	$868

An adult is a member, spouse, ex-spouse or a child who is no longer a dependent as defined by the Plan.

I understand that I must pay COBRA premiums from the date my coverage terminates to the present within 45 days from the date I sign this COBRA continuation election form. This COBRA election form must be returned within 60 days of receipt. Premiums are due by the first day of the month. After that I must pay the required premium within 30 days following the first day of the month for which premium is due. Any bills/claims received for that month may not be paid until payment is received in our office. I also understand the COBRA Premium rates may change at any time.

I elect the following for COBRA continuation coverage:

○ Self ○ Spouse ○ Dependents (Please list): _____

Please list the current and/or previous contractor you are/were employed by: _____

Member Name: _____ SS# or ID#: _____

Address, City, State, Zip: _____ Phone Number: _____

Signature: _____ Date: _____

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