ELECTION FORM FOR COBRA CONTINUATION COVERAGE

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* Instructions: To elect COBRA continuation coverage, complete this Election Form *
* and return it to us. Under federal law, you have 60 days after the date of this *
* notice to decide whether you want to elect COBRA continuation coverage under the *
* Plan. *
* *
* Send completed Election Form to: *
* *
* Fox Valley Laborers Health & Welfare Fund *
* 2371 Bowes Road *
* Suite 500 *
* Elgin, IL 60123-5523 *
* *
* Complete, sign and return this Election Form to the address with the enclosed *
* notice. It must be postmarked by the election date on the front of the letter. *
* *
* If you don't submit a completed Election Form by the required due date, *
* you'll lose your right to elect COBRA continuation coverage. If you reject *
* COBRA continuation coverage before the due date, you may change your mind as *
* long as you submit a completed Election Form before the due date. However, if *
* you change your mind after first rejecting COBRA continuation coverage, your *
* COBRA continuation coverage will begin on the date you submit the completed *
* Election Form. *
* *
* Please read the enclosed Initial COBRA Notification - COBRA Continuation *
* Coverage and Other Health Coverage Available Notice. *
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NOTE: There is no coverage under the Plan until a timely election is made and the applicable premiums paid, as described in the enclosed notice.

The following coverage is available. Indicate your selection by circling the coverage and premium below.

H & W COVERAGE CATEGORY(IES)	MEDICAL ONLY	MED DENTAL & VISION
Single Rate	$636.00	$684.00
Two Person Rate	$1271.00	$1368.00
Family Rate	$2006.00	$2159.00

Please list the name, social security number and birth date for each person to be covered under the above election.

Name	Relationship	Social Security #	Birth Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand the COBRA Continuation Coverage provisions and elect continuation coverage as indicated above. I further understand that failure to pay for this coverage or, in most cases, becoming covered under another group plan or Medicare, will result in loss of coverage.

Signature_____ Date_____