ELECTION FORM FOR COBRA CONTINUATION COVERAGE

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.

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	$758.00	$820.00
Two Person Rate	$1516.00	$1640.00
Family Rate	$2392.00	$2582.00

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_____