DMBA

COBRA ELECTION FORM

INSTRUCTIONS

To elect COBRA, complete this *COBRA Election Form* and return it to DMBA. Under federal law, you have 60 days after the date of this notice (or, if later, 60 days after the date that Plan coverage is lost) to decide whether you want to elect COBRA coverage under the Plan.

Return this completed form to DMBA by:

Note: Submit this form only once. If you sign it electronically online, do not send a duplicate by mail, email, or fax.

Mail: DMBA
P.O. Box 45530
Salt Lake City, UT 84145

Fax: 801-578-5933

Email: enrollmenthelp@dmba.com

Your notice must be in writing (using this form) and must be mailed, faxed, emailed, or signed electronically. Oral communications about COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, are not acceptable as COBRA elections and will not preserve COBRA rights. If mailed, your election must be postmarked no later than 60 days after the date of this notice (or, if later, 60 days after the date that Plan coverage is lost).

IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THE DUE DATE DESCRIBED ABOVE, YOU MAY LOSE YOUR RIGHT TO ELECT COBRA. If you reject COBRA before the due date, you may change your mind as long as you furnish a completed *COBRA Election Form* before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the date you submit the completed form.

APPLICANT INFORMATION (COMPLETE AND RETURN TO DMBA–REPORT CHANGES IMMEDIATELY)

Applicant name: _____

Former DMBA ID number: _____ Social Security number: _____

Birth date: _____ Phone: _____ Email: _____

Address: _____

* Plan availability based on location. If you choose Kaiser, please complete the appropriate Kaiser application for where you live.

CHOOSE YOUR MEDICAL PLAN:

Preferred Provider Organization (FSA eligible)

☐ DMBA PPO 90 ☐ DMBA PPO 70

High Deductible Health Plan (HSA and LPFSA eligible)

☐ DMBA HSA 80 ☐ DMBA HSA 60

Outside Health Maintenance Organization (FSA eligible)

☐ Kaiser (Plan availability based on location. If you choose Kaiser, please complete the appropriate Kaiser application for where you live.)

Other (FSA eligible)

☐ Deseret Choice Hawaii (Plan availability based on location.)
☐ Waive medical

CHOOSE YOUR DENTAL PLAN: ☐ Deseret Dental ☐ Deseret Dental *PLUS* ☐ Waive dental

CHOOSE YOUR VISION PLAN: ☐ VSP *with* an annual eye exam ☐ VSP *without* an annual eye exam ☐ Waive vision

CHOOSE YOUR HEALTH FLEXIBLE SPENDING ACCOUNT (FSA/LPFSA):

☐ Continue Health FSA/LPFSA ☐ Do not continue Health FSA/LPFSA

Please note: If you choose to continue the Health FSA/LPFSA, you must make monthly deposits to DMBA.

DEPENDENT (OR QUALIFYING INDIVIDUAL OTHER THAN APPLICANT) AND COBRA ELECTION

DEPENDENT NAME (FIRST, MIDDLE INITIAL, LAST)	RELATIONSHIP TO APPLICANT	BIRTH DATE	SOCIAL SECURITY NUMBER	COBRA COVERAGE ELECTED		
				MEDICAL	DENTAL	VISION
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
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				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Name printed: _____

Signature: _____ Date: _____

If the qualified beneficiary signing above is the covered applicant or spouse, this *COBRA Election Form* will be deemed to include an election on behalf of all of the qualified beneficiaries listed on this form, unless you check the box below:

☐ This is an election of self-only COBRA coverage and not an election on behalf of other qualified beneficiaries.