AIG AMERICAN GENERAL

Acknowledgement/Election of Cobra Continuation Right

The United States Life Insurance Company in the City of New York
Member of American International Group, Inc.
Attn: Client Services 3-A
P.O. Box 1583
Neptune, NJ 07754-1583

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

GROUP POLICY NO.: _____

	Name	DOB	Social Security #
☐ Employee			
☐ Spouse			
☐ Dependent Child			

QUALIFYING EVENT:

☐ Date Employment Ended: _____ *MONTH/DAY/YEAR*

☐ Date Employee Elected Medicare Primary: _____ *MONTH/DAY/YEAR*

☐ Date Employee Died: _____ *MONTH/DAY/YEAR*

☐ Date of Divorce: _____ *MONTH/DAY/YEAR*

☐ Date Child Ceases To Be Eligible: _____ *MONTH/DAY/YEAR*

1. **ELECTION/REFUSAL**

A) To be completed by the employee:

☐ I wish to continue my employee health insurance; ☐ I do not wish to continue my employee health insurance.
☐ I wish to continue health insurance for my spouse; ☐ I do not wish to continue health insurance for my spouse.
☐ I wish to continue health insurance for my child(ren); ☐ I do not wish to continue health insurance for my child(ren).

B) To be completed by spouse/dependent child.

SPOUSE: ☐ I wish to continue my health insurance; ☐ I do not wish to continue my health insurance.
CHILD: ☐ I wish to continue my health insurance; ☐ I do not wish to continue my health insurance.

Note: If you elect to continue insurance, you must complete the INSURANCE TO BE CONTINUED section below.

2. **INSURANCE TO BE CONTINUED:**

You may elect any combination shown below, but you can only continue insurance that was previously in force.

Employee:	☐ Major Medical Benefits	☐ Prescribed Drug Benefits	☐ Dental Benefits	☐ Vision Care Benefits
Spouse:	☐ Major Medical Benefits	☐ Prescribed Drug Benefits	☐ Dental Benefits	☐ Vision Care Benefits
Dependent Child(ren):	☐ Major Medical Benefits	☐ Prescribed Drug Benefits	☐ Dental Benefits	☐ Vision Care Benefits

3. **ACKNOWLEDGEMENT/SIGNATURE**

- I acknowledge that I have received and read the attached notice that explains the COBRA rights of continuation.
- I understand that if I elect to continue insurance, the payment of premium for it is my sole responsibility. I further understand that if premium is not received within 31 days of my premium due date, my insurance will automatically end as of the last day of the period for which premium was paid.

_____
EMPLOYEE SIGNATURE *DATE SIGNED*

_____
*CHILD SIGNATURE (FOR CHILD AGE 18 OR OVER)** *DATE SIGNED*
**EMPLOYEE SHOULD SIGN FOR A MINOR CHILD*

_____
SPOUSE SIGNATURE *DATE SIGNED*

RETURN THIS FORM TO THE EMPLOYER AT THE ADDRESS SHOWN ABOVE.