

CHART

**YOUR RIGHTS TO CONTINUE GROUP HEALTH CARE COVERAGE
UNDER NECA-IBEW WELFARE TRUST FUND**

Date of this Notice [Enter Date]

[Name of Member and/or Names of All Other Qualified Beneficiaries as appropriate]_____

[Address of Member and/or Addresses of Other Qualified Beneficiary]_____

[City, State, Zip Code]_____

This notice contains important information about your right to continue health care coverage in the NECA-IBEW Welfare Trust Fund. Each person has an independent right to continue health care coverage under the Plan.

Member's Name: [Enter] Member's Social Security Number: [Enter] Qualifying Event*: [Enter] Date of the Qualifying Event: [Enter Date]

If you do not elect to continue your health care coverage by the required date, your coverage will end on [Enter Date] .

Entitlement to COBRA Coverage for 36 Months.

Last Day to Elect COBRA Coverage: [Enter Date] * *Insert one of the following:*

Loss of eligibility

Death of member

Divorce or legal separation from member

Loss of "dependent" status

IMPORTANT – To elect continuation coverage you **MUST** complete the enclosed **"Enrollment Form"** and return it to us. You must mail it to the address shown on the "Enrollment Form." The completed "Enrollment Form" must be post-marked by [Enter Date] or delivered to the Fund Office by that date. If you do not submit a completed "Enrollment Form" by this date, you will lose your right to elect continuation. Important information is provided in the notice.