COBRA RIGHTS ACKNOWLEDGEMENT

I acknowledge that my COBRA benefits have been discussed regarding my rights to extend my group health plan coverage.

I understand that I (and/or) my plan dependents must complete and submit the COBRA Election Form within 60 days of the loss of coverage to be eligible for coverage continuation.

I understand that all costs for continuation coverage will be at my expense, and coverage will only be reinstated once payment is received. I understand my COBRA coverage will automatically terminate once I cease remitting the required monthly payments. **CAHC will not send notices or invoices of payments due**.

Employee Signature: _____ Date: _____

Printed Name: _____