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 one of the following:

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

Fax: 801-578-5933

Email: enrollmenthelp@dmba.com

This form must be completed in writing and mailed, faxed or emailed to the appropriate contact information specified above. 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.

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

Employee name: _____

Former DMBA ID number: _____ Social Security number: _____

Birth date: _____ Phone: _____ Email: _____

Address: _____

CHOOSE YOUR MEDICAL PLAN:

☐ Deseret Premier ☐ Deseret Select* ☐ Deseret Choice Hawaii* ☐ Deseret Value

☐ Deseret Protect ☐ Kaiser* ☐ Waive medical

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

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):

☐ Continue Health FSA ☐ Do not continue Health FSA

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

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

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

Address (if different from employee's address):_____

Name printed: _____

Signature: _____ Date: _____

If the qualified beneficiary signing above is the covered employee 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.

Please return this completed form to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530. You may also email it to enrollmenthelp@dmba.com or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.