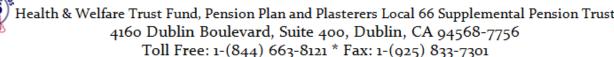
Northern California Plasterers Trust Funds



Email: plasterersinfo@hsba.com

ELECTION FORM COBRA CONTINUATION COVERAGE

I HAVE READ THIS FORM AND THE NOTICE OF RIGHTS ACCOMPANYING THIS FORM, AND I UNDERSTAND MY RIGHT TO ELECT CONTINUATION COVERAGE INDICATED BELOW.

I UNDERSTAND THAT IF I FAIL TO PAY ANY PREMIUM PAYMENT ON TIME, MY COVERAGE WILL TERMINATE. I ALSO UNDERSTAND THAT MY COVERAGE MAY TERMINATE FOR ANY OF THE REASONS LISTED IN THE TERMINATION OF COBRA CONTINUATION COVERAGE SECTION.

I AGREE TO KEEP THE ADMINISTRATION OFFICE INFORMED OF ANY CHANGES OF ADDRESS AND/OR FAMILY MEMBERS. I ALSO AGREE TO NOTIFY THE ADMINISTRATION OFFICE IF I OR ANY OTHER QUALIFIED BENEFICIARIES BECOME COVERED BY ANOTHER GROUP HEALTH PLAN OR MEDICARE.

Please check	the appropriate Qualifying Ev	ent which has caused the loss of yo	ur health	covera	ge:							
	Termination of employment, reduction in hours, voluntary quit or layoff											
	Death of member											
	Divorce											
	Medicare eligibility of the member											
	Dependent child exceeds Plan's age limit											
	Military Service											
Please check	the type of continued coverage	e you elect to have (ONE only):										
	I elect to continue medical, dental & vision coverage under the Plan at the current benefit level (life and accidental death & dismemberment benefits are not included).											
	I elect to continue coverage under the Plan for core medical benefits only (no Dental, no Vision).											
Signature	Date											
Member Infor	mation											
LAST NAME		FIRST NAME M.I.			SOCIAL SECURITY NUMBER							
MAILING ADDRESS (S	TREET OR P.O. BOX)					DATE OF	BIRTH					
CITY STATE/ZIP		TELEPHONE NUMBER			EMAIL ADDRESS							
	()											

DEPENDENTS TO BE COVERED UNDER COBRA

Please list your eligible dependents to be covered under COBRA. If you have children who were also dependents of the Participant and who have lost coverage, you must provide the following information and a birth certificate (if applicable) for each of them.

Dependent Information

DEPENDENT'S NAME	RELATIONSHIP TO PARTICIPANT*	SEX	DATE OF BIRTH		RTH	SOCIAL SECURITY NUMBER		

^{*}Relationship: Spouse, Child, Stepchild.

IMPORTANT NOTICE: If you acquire a child after you have begun coverage under COBRA, you may cover that child under this plan. Contact the Administration Office if you acquire a child while on COBRA coverage.

Please send the completed Election Form to:

Northern California Plasterers Health & Welfare Trust Fund 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756