DIRECT PAY
Election Form

Name (please print) ________________________ S.S.#________________

Date effective________________________

Please check one of the following boxes:

☐ I **accept** continuation coverage.

Please choose the coverage desired:

☐ **Individual:**

☐	Medical	$ 849.01 per month
☐	Excess Medical	$ 3.57 per month
☐	Dental	$ 47.22 per month

☐ **Family:**

☐	Medical	$ 1926.21 per month
☐	Excess Medical	$ 7.65 per month
☐	Dental	$ 79.19 per month

Life Insurance Group A-$25,000	$4.70 per month	____________
Life Insurance Group B-$25,000	$4.70 per month	____________
Life Insurance Group C-$10,000	$1.88 per month	____________

☐ I **decline** continuation coverage:

Signature____Date________________

FOR OFFICE USE ONLY

Processed into ☐FM ☐NYBEAS________________________Date________________

Sent to Business Office________________________Date________________

Cc: LD

Updated 0727/16