IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN (IAFF MERP)

COBRA SELF-PAYMENT RIGHT ELECTION FORM

INSTRUCTIONS: Under federal law, you have 60 days after the date of the "Notice of Right to Elect COBRA Self-Payment of Contributions" (Notice E) to decide whether you want to elect to continue contributions to the Trust by self-payment under COBRA. To elect to continue contributions to the Trust by self-payment under COBRA, you should read the enclosed Notice E and complete this Election Form and return it to:

IAFF Medical Expense Reimbursement Plan Trust Office
c/o Benefit Programs Administration
1200 Wilshire Blvd, 5th Floor
Los Angeles, CA 90017
Email: IAFFMERP@bpabenefits.com

This Election Form must be completed and returned by first class mail. It must be post-marked no later than *11/14/2026.*

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect to self-pay under COBRA. If you reject your COBRA right to self-pay before the due date, you may change your mind as long as you furnish a new completed Election Form electing coverage before the due date.

I elect to continue contributions by self-payment under COBRA in the Medical Expense Reimbursement Plan (the "Plan") of the Trust as indicated below:

Name: _____
Date of Birth: _____
SSN (or other identifier): _____
Relationship to Employee: _____
Name of Employer: _____

I choose to make my first COBRA payment and monthly COBRA payments by the following method (select one of the following methods):

☐ Deduct entire 18 monthly payments from Lump Sum Transfers or Individual Account balance (if applicable) (irrevocable election and benefit commencement after postmark deadline)
☐ Monthly Deductions from Lump Sum Transfers or Individual Account balance (if applicable) until I deliver written direction to stop (benefits will not commence until COBRA contributions stop)
☐ Mail check for entire 18 months of payments (irrevocable election and benefit commencement after postmark deadline)
☐ Mail checks to Trust Office monthly (benefits will not commence until COBRA contributions stop)

_____	_____
Signature	Date
_____	_____
Print Name	Phone
_____	_____
Address	Email