



COBRA ACKNOWLEDGEMENT FORM FOR SPOUSE

Your spouse was given a copy of an initial COBRA notice upon commencement of employment, with instructions to deliver a copy to you. This certifies that you have received a copy of your rights pertaining to limited continuation of coverage for health benefits for you and your covered dependents under the Public Health Services Act.

(Print EMPLOYEE'S name)

(Print EMPLOYEE'S SSN)

(Print SPOUSE'S name)

Governmental Entity: (check one or indicate other)

- | | | |
|---|---|---|
| <input type="checkbox"/> BOCC | <input type="checkbox"/> Lee County Clerk of Courts | <input type="checkbox"/> Court Administration |
| <input type="checkbox"/> Port Authority | <input type="checkbox"/> Tax Collector | <input type="checkbox"/> Property Appraiser |
| <input type="checkbox"/> Elections | <input type="checkbox"/> Other _____ | |

Spouse's Signature

Date

Please return this completed form to:

Lee County Human Resources
Attn: Benefits
P.O. Box 398
Fort Myers, Florida 33902