



Receipt of Notice of COBRA Continuation of Coverage Rights

I _____ confirmed that **SCMG CORP DBA Canales Furniture** has given me the proper verbal information and the **Notice of COBRA Continuation of Coverage Rights handbook**. I was informed that COBRA requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events. Group health coverage for COBRA participants is often more expensive than the amount that active employees are required to pay, since the employer usually pays 50% on Medical Insurance only of the cost of employees' coverage and 100% of cost will be charged to individuals receiving continuation coverage. **I also understand that if I resigned of work in the middle of the month I will be 100% responsible to pay the cost of 50% employee contribution for the last month, authorizing _____ to deduct monthly amount out of my last payroll check.**

By signing this form, I agree with the information above.

Employee Signature

Date

Witness Signature

Date

SCMG CORP DBA Canales Furniture

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