

# Continuation of Medical/Dental Benefits Election Form

Subject to the terms stated in your Summary Plan Description, Continuation of Medical/Dental benefits may be available for you and/or your covered Dependents. Please refer to the Summary Plan Description for terms and limitations. To apply for continuation of Medical/Dental benefits, please complete and return this form to your employer (or previous employer, in the event of termination of employment).

Employer name \_\_\_\_\_

Group number \_\_\_\_\_

## Employee information

Employee name \_\_\_\_\_

Social Security number \_\_\_\_\_ Phone \_\_\_\_\_

Street address \_\_\_\_\_ Apt / Suite / PO box number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

## Dependent information

Dependent name \_\_\_\_\_

Social Security number \_\_\_\_\_

## Qualifying Event

Check the qualifying event that applies to you and indicate the date of the qualifying event in the blank

- Termination Last date employed \_\_\_\_\_
- Medicare Date covered by Medicare \_\_\_\_\_
- Legal Separation Date Legal Separation Filed \_\_\_\_\_
- Dependent Child Date dependent child ceased to be eligible dependent \_\_\_\_\_
- Reduced Hours Date hours reduced \_\_\_\_\_
- Employee's Death Date \_\_\_\_\_
- Divorce Date Divorce Effective \_\_\_\_\_
- Other: \_\_\_\_\_ Date \_\_\_\_\_

Employer complete premium due for coverages. Date form is given to insured \_\_\_\_\_

| Medical  | Dental   |
|--|--|
| <input type="checkbox"/> Individual only _____/Month       | <input type="checkbox"/> Individual only _____/Month       |
| <input type="checkbox"/> Individual and spouse _____/Month | <input type="checkbox"/> Individual and spouse _____/Month |
| <input type="checkbox"/> Individual and child _____/Month  | <input type="checkbox"/> Individual and child _____/Month  |
| <input type="checkbox"/> Family _____/Month                | <input type="checkbox"/> Family _____/Month                |

(Note: Rates are subject to any employer changes to plan.)

**PREMIUMS MUST BE PAID TO THE EMPLOYER OR THE COBRA ADMINISTRATOR SELECTED BY YOUR EMPLOYER.**

For Federal Continuation, the initial premium is due within 45 days after the date Continuation of coverage is elected. Subsequent premiums are due monthly by the \_\_\_\_ of the month. If the employer does not receive full payment within 31 days of the due date, your coverage will be cancelled.

## Signature of Person Electing or Waiving Continuation

- I elect continuation
- I refuse continuation

Employee signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse signature \_\_\_\_\_ Date \_\_\_\_\_

Dependent signature \_\_\_\_\_ Date \_\_\_\_\_

(If Over Age 19)

**SPOUSE AND DEPENDENT SIGNATURES ARE REQUIRED IF ANY DEPENDENT COVERAGE IS BEING WAIVED.**

If the Federal Continuation (COBRA) provision applies, a completed form must be returned within 60 days after or the later of: 1) the date that you would lose coverage, or 2) the date that you are sent notice of your right to elect COBRA Continuation. An election is considered to be made on the date that it is sent to your employer or plan sponsor. Failure to return form within the specified time may result in the loss of Continuation privilege.

NOTE: If you are deemed Totally Disabled by the Social Security Administration, send a copy of the notification to our company as you may be entitled to an additional 11 months of coverage. Please call us for more information.

