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 Name: ______________________ Social Security Number: ______________

Dependent Name: ______________________ Social Security Number: ______________

Your Address: ____

Your Phone Number: ( ) ______________________

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 an eligible Dependent: ________
- ❏ Reduced hours — Date hours reduced: ________
- ❏ Employee's Death — Date: ________
- ❏ Divorce — Date Divorce Effective: ________
- ❏ Other

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

	Medical	Dental
Individual Only	________ /Month	________ /Month
Individual + Spouse	________ /Month	________ /Month
Individual + Child	________ /Month	________ /Month
Family	________ /Month	________ /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 EMLOYER.

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 canceled.

SIGNATURE OF PERSON ELECTING OR WAIVING CONTINUATION:

❏ I elect continuation
❏ I refuse continuation

Employee: ______________________ Date: ______________

Spouse: ______________________ Date: ______________

Dependent: ______________________ Date: ______________
(Over Age 19)

SPOUSE AND DEPENDENT SIGNATURES ARE REQUIRED IF ANY DEPENDENT COVERAGES ARE 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 the 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.