



THIS SECTION MUST BE COMPLETED

Employee Member Number

Grid for Employee Member Number (12 boxes)

Health Group Number

Grid for Health Group Number (12 boxes)

Dental Group Number

Grid for Dental Group Number (12 boxes)

Vision Group Number

Grid for Vision Group Number (12 boxes)

COBRA or State Continuation of Coverage Application

Continuation of Medical/Dental benefits may be available for you and/or covered Dependents. See your employer for eligibility. To apply for continuation of Medical/Dental benefits, complete and return this form to your Employer (or previous Employer in the event of termination of employment).85

TO BE COMPLETED BY EMPLOYER ONLY

Employee Name (First, Middle Initial, Last)

Grid for Employee Name (28 boxes)

Employer Name

Grid for Employer Name (28 boxes)

Date of Hire

Grid for Date of Hire (MM/DD/YYYY)

- STATE CONTINUATION OF COVERAGE (Applicable to employers with less than 20 employees and church and federal government groups)
COBRA (Applicable to employer with 20 or more employees)

FOR STATE CONTINUATION OF COVERAGE OR WHEN THE EMPLOYER DOES COBRA BILLING IF YOU ELECT TO CONTINUE COVERAGE PAYMENT MUST BE SENT TO:

PAYABLE ON OR BEFORE THE DAY OF EACH MONTH COMMENCING ON IN ORDER TO AVOID CANCELLATION OF YOUR COVERAGE.

THE MONTHLY PREMIUM FOR COVERAGE AS ELECTED ABOVE IS \$ FOR MEDICAL \$ FOR VISION AND \$ FOR DENTAL THERE MAY BE AN ADDITIONAL 2% CHARGE ADDED FOR COBRA AND/OR UP TO 50% FOR COBRA DISABILITY BENEFICIARIES.

LAST DAY WORKED

Grid for Last Day Worked (MM/DD/YYYY)

LAST DAY OF GROUP COVERAGE

Grid for Last Day of Group Coverage (MM/DD/YYYY)

EMPLOYEE/DEPENDENT NOTIFICATION DATE

Grid for Employee/Dependent Notification Date (MM/DD/YYYY)

GROUP ADMINISTRATOR SIGNATURE

DATE

TO BE COMPLETED BY EMPLOYEE

DATE OF QUALIFYING EVENT

Grid for Date of Qualifying Event (MM/DD/YYYY)

QUALIFYING EVENT

EVENT FOR EMPLOYEE

- Termination of Employment, Non-medical Leave of Absence, Bankruptcy of Employer, Work Related Disability, Non-work Related Disability, Reduction in Hours, Medicare Entitlement

EVENT FOR DEPENDENT

- Death of Covered Employee, Child's Loss of Dependent Status, Bankruptcy of Employer, Divorce or Legal Separation, Employee's Entitlement to Medicare

Based on the qualifying event(s) checked above, list below the individuals to be covered under continuation and the coverage desired.

Table with columns: NAME, RELATIONSHIP, M/F, BIRTHDATE, PRIMARY CARE PROVIDER NAME, PROVIDER NUMBER, COVERAGE TYPE (HEALTH, DENTAL, VISION)

MAILING ADDRESS OF PERSON MAKING ELECTION

SOCIAL SECURITY NUMBER OF PERSON MAKING ELECTION

Grid for Social Security Number (MM/DD/YYYY)

PHONE NUMBER

I acknowledge that I have read the front and backside of this application and certify that I agree to all matters covered therein.

SIGNATURE OF PERSON MAKING ELECTION

DATE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

You are hereby notified that as a terminated employee, or an employee who has lost group coverage because of a reduction in work hours, you have the right to elect to continue group coverage for yourself and your dependents, if applicable, for a maximum period of 18 months. This coverage may end sooner if you become covered under another group plan which does not contain a pre-existing condition limitation **(COBRA and State Law)**, or the employer discontinues coverage for active employees, or premium is not paid when due, or you become entitled to Medicare benefits including Medicare Disability, **(COBRA and State Law)**, or Medicaid benefits **(State Law)**, or cause exists that would result in termination of this coverage for a similarly situated active employee. The 18 months may be extended to 29 months for a terminated member if the member is determined under the Social Security Act to have been disabled any time during the first 60 days from the employee's termination or reduction in hours; however, coverage may end on the date on which the member is determined under the Social Security act to no longer be disabled **(COBRA)**.

You are hereby notified that as a legally separated or divorced spouse, or a spouse/dependent of a deceased employee, **(COBRA or State Law)** or a spouse/dependent of an employee who selected Medicare as his/her primary coverage leaving you without coverage, or a dependent who is no longer eligible under the employee's coverage, you have the right to elect to continue group coverage for a maximum period of 36 months **(COBRA)** or 18 months **(State Law)**. This coverage may end sooner if you become covered under another group plan which does not contain a pre-existing condition limitation **(COBRA and State Law)**, or the employer discontinues coverage for active dependents, or premium is not paid when due, or you become entitled to Medicare benefits including Medicare Disability **(COBRA and State Law)**, or Medicaid benefits **(State Law)** or cause exists that would result in termination of this coverage for a similarly situated active dependent.

If group coverage is discontinued for active employees' dependents, the COBRA or State Law will also be discontinued as of the same effective date the group is discontinued. Any premiums paid beyond that date will be refunded to the member.