REQUEST FOR CONTINUATION OF HEALTH COVERAGE

Part 1 – EMPLOYER INFORMATION (to be completed by employer)

Employer's Name	Date of Qualifying Event	Date Group Coverage Ends

Employee's Name	Employee's Social Security #	Date of Notice	Last Date to Elect

INSTRUCTIONS

Check all appropriate boxes

Eligible:	Yes	No
Employee		
Spouse		
Child/ren		

Qualifying Event

18 mo. Maximum	**29 mo. Maximum**	**36 mo. Maximum for Dependents Only**
☐ Termination of Employment	☐ Total Disability	☐ Divorce or Separation
☐ Reduction in Hours		☐ Child ceasing to be a dependent
☐ Retirement (to age 65)		☐ Employee entitled to Medicare
		☐ Death of an Employee

Part 2 – COVERAGE AVAILABLE FOR SELECTION AND COSTS TO ELECTOR (to be completed by employer)

Supplemental Medical	**Plan 1**	**Plans 2**
☐ Employee Only	$	$
☐ Employee & Spouse	$	$
☐ Employee & Child/ren	$	$
☐ Employee & Family	$	$

Signature of Authorized Representative: _____ Date: _____

Part 3 – ELECTOR INFORMATION (to be completed by elector)

INSTRUCTIONS: Complete the following information for each person (including yourself) for whom continuation of coverage is elected.

Last Name	**First Name**	**MI**	**Relationship To Employee**	**Birth Date (MM/DD/YY)**	**Social Security #**

INSTRUCTIONS:

Enter appropriate cost from Part 2

COVERAGE COST

Supp. Medical: $

Send Bills and Correspondence to:

Name:
Street:
City:
State: Zip Code
Phone Number ( )

Part 4 – FAMILY EMPLOYMENT (to be completed by elector)

Is anyone listed above employed? ☐ Yes ☐ No If Yes, Persons's Name

Employer's Name Employer's Address (Street, City, State, Zip Code)

Is the person covered by another Group Health Care Plan? ☐ Yes ☐ No

If Yes: Plan Name Group #

Part 5 – I CERTIFY THAT THE INFORMATION IS TRUE AND COMPLETE

Signature: _____ Date: _____

Check whichever is applicable:
☐ Employee (for self or self & dependents)
☐ Spouse (☐ current ☐ former)
☐ Child
☐ Legal Guardian for _____

Return with check for total in Part 3 payable to your employer to the attention of:

Human Resources Manager