

# election

## of insurance continuation



**Check items that apply. Complete entire form. *Please print in black ink.***

Employee coverage     Spouse coverage     Child(ren) coverage

Name of Policyholder (Employer) \_\_\_\_\_

Employee name \_\_\_\_\_ Social Security number \_\_\_\_\_

Policy and Division number \_\_\_\_\_ Certificate number \_\_\_\_\_

1. Continuation of coverage:     Yes     No

2. Date of qualifying event: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

3. Type of qualifying event:

- a.  Employee termination/reduction in hours worked
- b.  Divorce or legal separation
- c.  Death of employee
- d.  Child no longer eligible
- e.  Other, please specify: \_\_\_\_\_

**Please complete the following for EACH person to be covered under this continuation.**

Name	Date of birth	Relationship to employee:			Social Security number
		Self	Spouse	Child	
1 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6 _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If you are electing insurance continuation, you must notify the employer if:

- a. You become covered under another group plan;
- b. You become entitled to Medicare; or
- c. You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group plan.

Return this form and your premium payment to the employer by: \_\_\_\_\_

**All checks should be made payable to the employer.**

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

Employer verification \_\_\_\_\_ Date \_\_\_\_\_