

**CONTINUATION ELECTION FORM**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice of Right to Continue Group Medical Expense Coverage.**

Your group medical expense coverage would normally terminate as of \_\_\_\_\_. You may exercise your right to Individual Purchase as explained in your booklet-certificate; or, state law permits you to continue the group medical expense coverage, while the group plan is in force. (Individual Purchase is also available at the end of the continuation period, provided you are not then covered for similar benefits which would result in over insurance.) Please refer to your booklet-certificate for a complete description of your continuation rights.

If you decide to continue the group medical expense coverage, please complete the bottom of this form and return it to the employer's office shown below within 60 days following the later of: (a) the date the group coverage would otherwise end; or (b) the date of this notice. This notice must be returned to the employer within this 60 day period; otherwise the right to elect continuation ends. It will then be your responsibility to pay monthly premium of \$\_\_\_\_\_. (This includes a monthly administrative fee of 2%.) The first payment must be made within 45 days of the date of your election. Thereafter, payments must be received in the office no later than 30 days following the due date indicated below.

**Applicant to Complete:**

- 1. Coverage is to be continued: [ ] Yes [ ] No If "yes" is checked, please continue.
- 2. Coverage is to be continued for: [ ] Member [ ] Member & Dependents [ ] Dependents

**Note: Current Dependents may be continued only if they were covered under the group health plan.**

\_\_\_\_\_  
Qualifying Event  
(Termination of Employment, Etc.)

\_\_\_\_\_  
Signature of Qualified Person

\_\_\_\_\_  
Date of Qualifying Event

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Qualified Person's Name

\_\_\_\_\_  
Employer's Name

\_\_\_\_\_  
Qualified Person's Address

\_\_\_\_\_  
Employer's Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

**Please notify us if a Qualified Dependent has a different address and requires notification of continuation due to a qualifying event.**