Continuation Coverage **Election Form**

Participating Organization:			Group I.D. Number:	Date of Qualifying Event:
Employee Name:	(Last)		(First)	(Middle)
Occupation:			Requested Effective Date:	☐ Male ☐ Female ☐ N/A
Street Address:				City:
State:	Zip:	Country:		Telephone:
Social Security Number:			Date of Birth:	

Dependents (attach a separate sheet, if needed)

☐ I do *not* wish to cover my eligible dependents				☐ I wish to cover my eligible dependents	
Name (Last, First, Middle)				**Date of Birth & Date of Marriage**	**Social Security Number**
Spouse					
Dependent Child #1	☐ Male	☐ Female	☐ N/A		
Dependent Child #2	☐ Male	☐ Female	☐ N/A		
Dependent Child #3	☐ Male	☐ Female	☐ N/A		

FOR DETERMINATION OF CONTINUATION ELIGIBILITY, PLEASE REFER TO THE CONTINUATION ELIGIBILITY SECTION OF YOUR CERTIFICATE OF INSURANCE FOR DETAILS.

Qualifying Event

- ☐ Termination of employment
- ☐ Medicare eligibility
- ☐ Insured employee's death
- ☐ Dependent child's loss of eligibility
- ☐ Reduction in hours to less than 30 hours per week
- ☐ Insured employee's divorce/separation

I do hereby elect continuation coverage. I agree to pay the premium due on the first day of each month to the Participating Organization listed above.

Premium due: ☐ Employee ☐ Employee + 1 Dependent ☐ Family ☐ Employee + Children

Signed: _____ Dated: _____