Continuation Coverage Election Form

Participating Organization:			Group I.D. Number:
Date of Qualifying Event:			
Employee Name: (Last)		(First)	(Middle)
Requested Effective Date:	Occupation:		Sex: ☐ Male ☐ Female
Street Address:			City:
State:	Zip:	Country:	Telephone:
Social Security Number:		Date of Birth:	
What is your filing status with the IRS? ☐ W-2 ☐ 1099 ☐ No Compensation			

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 to Spouse	Social Security Number
Spouse		
Dependent Child #1 ☐ Male ☐ Female		
Dependent Child #2 ☐ Male ☐ Female		
Dependent Child #3 ☐ Male ☐ Female		
For dependent children age 19 or older, please indicate name and address of college or university:		

FOR DETERMINATION OF CONTINUATION ELIGIBILITY, PLEASE REFER TO THE CONTINUATION ELIGIBILITY SECTION OF YOUR SUMMARY PLAN DESCRIPTION BOOKLET 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: Single________ Single + 1 Dependent________ Family________

Signed____ Dated__________________________

Updated 04/05