

**GROUP COVERAGE
CONTINUATION
ELECTION FORM**
(20 Or More Employees)



Date form distributed _____

Effective date _____

Date election period expires _____

- This form is to be completed whether you wish to apply for continuation coverage or decline continuation coverage.
- **To continue coverage**, complete all sections. **To decline coverage**, complete only sections 1, 2, and 5.
- Return the completed form to your employer before the election period expires (above).

Please type or print in ink.

SECTION 1 QUALIFYING INDIVIDUAL INFORMATION

Last Name		First		M.I.	Social Security No.		Group No.	
Street Address				City		State	Zip Code	Daytime Phone No.
Date Of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					

SECTION 2 QUALIFYING EVENT INFORMATION

I am eligible for continuation of medical coverage due to (check one):

Termination of employment or reduction in hours

Divorce from a covered employee – Date of event: _____

Covered dependent no longer meets eligibility requirements – Date of event: _____

Death of a covered employee

Is anyone applying for continuation covered by other group insurance? Yes No

If yes, name of insured: _____ Insurance carrier: _____

If you are not the covered employee, give name and social security number of employee who is primary on the policy:
Name: _____ Social Security No.: _____

SECTION 3 CONTINUATION PREMIUM RATES

After you enroll, each premium payment must be received by the employer **before the first day of each month** for which you wish to continue coverage. A grace period of 30 days will be granted for the payment of each premium. Your coverage will be cancelled if the employer does not receive your premium on time.

You may continue any coverage you had before the qualifying event listed in Section 2. **Please indicate your choice of coverage** (medical only, or medical + dental if available) **and your family's participation level** by checking *one box* below:

Coverage	Employee Only	Employee + Spouse	Employee + Family	Employee + Children
Medical Only	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$
Medical + Dental	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$

SECTION 4 DEPENDENTS CONTINUING COVERAGE

Please list all dependent family members continuing coverage.

Last Name	First Name	M.I.	Birth Date	Sex	Relationship	Last Name	First Name	M.I.	Birth Date	Sex	Relationship

SECTION 5 SIGNATURE OF QUALIFYING INDIVIDUAL

ACCEPT: I have read and understand the notification of rights on the reverse side. I hereby **request** continued coverage as indicated above. I understand that failure to make timely payment of required premiums will result in permanent loss of this coverage. While under coverage I expressly authorize any licensed physician, hospital, insurance company, or person that has any record or knowledge of my health or the health of any listed family member to furnish to PacificSource with any records concerning myself or any family member named on this application for the purpose of collecting information in connection with a claim for benefits. A photographic copy of the authorization will be as valid as the original.

Signature

Date

DECLINE: I have read and understand the notification of rights to continue health coverage on the reverse side. I hereby **decline** continued coverage available to me as a result of the qualifying event indicated above.

Signature

Date

NOTIFICATION OF RIGHT TO CONTINUE GROUP HEALTH COVERAGE

Qualifying Events and Continuation Period

The following Qualifying Events entitle otherwise eligible individuals to continue coverage under the employer's group plan for the lengths of time listed below. Each qualified beneficiary (employee, spouse, or dependent child) may elect continuation together or separately.

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months ¹
Employee's divorce	Spouse and children may continue for up to 36 months ²
Employee's eligibility for Medicare benefits	Spouse and children may continue for up to 36 months
Employee's death	Spouse and children may continue for up to 36 months ²
Child no longer qualifies as a dependent	Child may continue for up to 36 months ²

¹ If the employee is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, coverage may be continued for up to 29 months.

² The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.

When Coverage Ends

Your continuation coverage will end before the end of the continuation period listed above if any of the following occurs:

- Your continuation premium is not paid on time;
- You become covered under another group health plan that does not exclude or limit treatment for your pre-existing conditions;
- You become entitled to Medicare benefits;
- The group discontinues its health plan and no longer offers a group health plan to any of its employees.

Type of Coverage

You may continue any coverage you had before the qualifying event. If your employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental, or medical only. If your employer provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

Dependent Coverage

To continue coverage for your eligible dependents, you must list your family members in Section 4 on the reverse side of this form. If your dependents were not covered prior to the qualifying event, they may enroll now or later subject to the same rules that apply to active employees (including late enrollee provisions).

Enrollment Deadline

To continue coverage, this form must be returned to your employer within 60 days of the date your group coverage ends, or the date your election period expires (noted on the reverse side), whichever is later. If your continuation election form is not returned by the deadline, your coverage will end on the last day you were eligible under the group health policy.

Premium Payments for Continued Coverage

The cost of continuation coverage is your responsibility. You must pay your premium to the employer before the first day of each month for which you want coverage. The employer will include your continuation premium with the group's monthly payment to PacificSource. PacificSource cannot accept premium directly from you. If your premium is not paid on time, your coverage will end. If your coverage is cancelled due to a missed payment, it will not be reinstated for any reason. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.