GROUP COVERAGE CONTINUATION ELECTION FORM
(19 or Fewer 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).
- You may continue medical coverage only. Dental or vision coverage is not included.

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	Marital Status
	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ 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:_____________________

☐ 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. Your coverage will be cancelled if the employer does not receive your premium on time.

	Employee Only	Employee + Spouse	Employee + Family	Employee + Children
Medical Coverage Premium:	$	$	$	$

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

To be eligible for continuation coverage, you must have been insured under the employer's PacificSource group health insurance policy for at least the last three continuous months. If your employer changed health insurance plans or carriers during that time without a break in coverage and you were enrolled in your employer's plan continuously for the last three months, you will be eligible. If you have been covered under the employer's policy for less than three months, or if there was a break in coverage during the last three months, you are not eligible for continuation.

The following Qualifying Events entitle otherwise eligible individuals to continue coverage under the employer's group plan for the lengths of time listed below:

Qualifying Event	***Continuation Period***
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 6 months; spouse and children *may not* continue separately from employee
Employee's divorce	Spouse and children may continue for up to 6 months
Employee's death	Spouse and children may continue for up to 6 months

When Coverage Ends

Your continuation coverage will end before the end of the six-month maximum 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;
- You become entitled to Medicare benefits;
- A child no longer qualifies as an eligible dependent (due to age, marriage, loss of student status, etc.);
- The group discontinues its health plan.

Plan Changes or Termination

While it does not currently intend to do so, 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. If your employer terminates the health plan, your continuation coverage will also terminate.

Enrollment Deadline

To continue coverage, this form must be returned to your employer within 31 days after your last day of coverage under the group policy. The date your election period expires is noted on the reverse side of this form. 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.

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 not enroll in the continuation coverage at this time. Only newborn children and newly acquired spouses without other group health plan coverage may enroll in the continuation coverage after the qualifying event. Please note that dependent children who no longer qualify for coverage under the group policy (because of age, marriage, loss of student status, etc.) are not eligible for continuation coverage.

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.