

**GROUP COVERAGE  
CONTINUATION  
ELECTION FORM**  
(For Oregon groups with  
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 available.

*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.

	Employee Only	Employee + Spouse	Employee + Family	Employee + Children
<b>Medical Coverage Premium:</b>	\$ _____	\$ _____	\$ _____	\$ _____

**SECTION 4 DEPENDENTS CONTINUING COVERAGE**

**Please list all dependent family members continuing coverage.**

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, an employee 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. An employee that has been covered under the employer's policy for less than three months, or has had a break in coverage during the last three months is 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. Each covered person (employee/subscriber) or qualified beneficiary (employee, spouse, or dependent child) may elect continuation together or separately.

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

### When Coverage Ends

Your continuation coverage will end before the end of the nine-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;
- The group discontinues its health plan and no longer offers a group health plan to any of its employees.

### 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 and your initial premium must reach your employer within 31 days after your last day of coverage under the group policy, or within 10 days after you receive notification of your continuation rights, whichever is later. 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 include 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 or adopted children may enroll in the continuation coverage after the qualifying event.

### Premium Payments for Continued Coverage

The cost of continuation coverage is your responsibility. You must pay your premium to your former 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.