

COBRA GROUP COVERAGE CONTINUATION NOTICE

To: _____ Group Number: _____

Date of Notice: _____ Subscriber I.D. Number: _____

Your eligibility for group insurance coverage terminated on _____. If your coverage terminated because of one of the following categories of events, you have the right to continue the medical, dental, vision, and/or prescription drug coverage you now have under the Group Policy for yourself and your insured dependents:

- A. the death of the covered employee;
- B. the termination (other than for gross misconduct) or reduction in hours of employment of the covered employee;
- C. the divorce of the covered employee;
- D. the covered employee becoming entitled to Medicare benefits;
- E. your disqualification from eligibility due to no longer meeting the plan definition of dependency (if you were formerly a covered dependent).

From the date of the qualifying event, above, you have the right to continue coverage for the following period of time:

36 months – if the termination was a result of category A, C, D, or E.

18 months – if the termination was a result of category B.

In order to retain coverage under the Group Policy, you will be required to make monthly premium payments of \$_____ for yourself and/or any covered dependents. Payments should be submitted to the address shown below:

(Employer's Name and Address)

You have 60 days from the date of this notice to elect continuation coverage. Your first monthly premium payment must be received within 45 days of your election. Subsequent monthly premium payments must be received by the first day of each month.

NOTE: Please keep your Certificate of Group Insurance and ID card if you do elect to continue group coverage.

You may convert to an individual policy of hospital-surgical insurance now or when your group continuation coverage terminates at the end of the 18 or 36 month period. If you choose Conversion Coverage, you must submit the appropriate application along with the applicable premium directly to _____ within 30 days of the termination of your Group Policy or your group continuation coverage.

Check one:

- I DO elect to CONTINUE coverage under the Group Policy, and agree to the conditions and requirements outlined above.
- I DO NOT elect to CONTINUE coverage under the Group Policy.
- I DO elect to CONVERT to an individual policy of hospital-surgical insurance at this time. Please send me the appropriate outline of coverage and application.

Date: _____ (Signature of Applicant)