

STATE CONTINUATION ENROLLMENT FORM

Due to the event checked below, coverage for you and/or your spouse and dependent children (if any) under the (carrier name) \_\_\_\_\_ Plan offered by \_\_\_\_\_ [enter employer name] will terminate/has been terminated effective: \_\_\_\_\_ due to:

- checkbox termination of employment
checkbox reduction of hours
checkbox death of employee
checkbox enrollment in Medicare and your employer's plan does not allow you to cover your dependents separately
checkbox divorce or legal separation from employee
checkbox dependent child ceasing to be a "dependent" under the terms of the (enter Carrier Name) contract.

By completing and returning this form to \_\_\_\_\_ [enter the name and address of the individual at the employer to whom the election form must be sent], you (your spouse or dependent children) may elect to continue coverage under the (carrier name) \_\_\_\_\_ Plan. The attached Notice of Continuation Coverage explains your rights and obligations.

If after reading the attached notice you choose to elect continuation coverage, you must sign, date and return this form within 60 days after the later of (i) the date you lose coverage, or (ii) the date this form and attached notice are provided to you. Therefore, the completed enrollment form must be received by: \_\_\_\_\_ [enter date]. If you elect continuation coverage, coverage will continue for you, your spouse and dependent children, if any. If you do not elect continuation coverage, your spouse and dependent children may independently elect continuation coverage by signing, dating and returning this form within the applicable time period.

If continuation coverage is elected, the required premium of \$ \_\_\_\_\_ must be paid by \_\_\_\_\_.

I hereby acknowledge that I have read the attached Notice of Termination of Coverage and

- checkbox Elect STATE CONTINUATION coverage under the (carrier name) \_\_\_\_\_ Plan.
checkbox Do not elect STATE CONTINUATION coverage under (carrier name) \_\_\_\_\_ Plan.
checkbox (Spouse or Ineligible Dependent Only) elect STATE CONTINUATION coverage in the amount of \$ \_\_\_\_\_.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

RETURN THIS FORM TO: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_