NOTICE OF INSURANCE CONTINUATION

If you are losing coverage under your dental group policy, you may be eligible for a continuation of your coverage.

An insured employee and/or eligible dependent(s) of an insured employee may continue coverage for up to 18 months if coverage is lost for any of the following reasons:

1) A reduction in hours worked
2) Termination of employment (for reasons other than gross misconduct).
3) The employee retires and the employer has filed Chapter 11 reorganization.

This continuation may be extended up to an additional 11 months. If you are continuously disabled according to Social Security rules from the time the continuation period began.

A spouse of an employee may be eligible to continue benefits up to 36 months, if coverage is lost for any of the following reasons:

1) The death of your spouse;
2) Divorce or legal separation from your spouse; or
3) Your spouse becomes entitled to Medicare.

A dependent child may be eligible for continuation of coverage of up to 36 months, if coverage is lost for any of the following reasons:

1) The death of a parent;
2) Parents' divorce or legal separation;
3) A parent becomes entitled to Medicare; or
4) The dependent ceases to be a "dependent child" as defined by the group contract.

The continuation of coverage may be shortened for any of the following reasons:

1) The employer no longer provides group coverage to any of its employees;
2) The premium for your continuation coverage is not paid;
3) You become covered under another group plan*;
4) You become entitled to Medicare; or
5) You were divorced from a covered employee and subsequently remarry; and are covered under your new spouse's group plan.

*If your new group plan limits benefits you would otherwise receive due to a pre-existing condition, you may be eligible to continue your coverage.

ELECTION OF INSURANCE CONTINUATION	*- Check Those That Apply and Complete Entire Form -*
	☐ Employee Coverage ☐ Child(ren) Coverage
	☐ Spouse Coverage ☐ No Continuation of Coverage

_____ _____
Name of Employer Policy and Division Number

_____ _____ _____
Employee Name Social Security Number Certificate Number

1. Date of qualifying event: _____/_____/_____

2. Type of qualifying event:
   a. _____ Employee termination/reduction in hours worked.
   b. _____ Divorce or legal separation.
   c. _____ Death of employee.
   d. _____ Child no long eligible.
   e. _____ Other, please specify: _____

Please complete the following for EACH person to be covered under this continuation:

Name	Birthdate	Relationship to Employee			Social Security Number
		Self	Spouse	Child	
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____
_____	_____	☐	☐	☐	_____

If you are electing insurance continuation, you must notify the employer if:

a) You become covered under another group plan;
b) You become entitled to Medicare; or
c) You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group plan.

Return this form and your premium payment to the employer by: _____
All checks should be made payable to the employer.

Applicant Signature _____ Date _____

Employer Verification _____ Date _____