

Planholder Name:	Group Plan #:	Date:
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Planholder's Address:

Name of Insured Employee: (Last, First, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:	Date of Birth:	Class:
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Names of Continuing Eligible Dependents (If more space is needed please attach a separate sheet of paper)

Full Name: (Last, First, MI)	Sex	Social Security #	Date of Birth	Relationship to Employee
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

Home Address:

Reason for Termination of Insurance:	Date of Termination:
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New Jersey Law permits an employee whose group coverage terminates due to a reduction of work hours or termination of employment, other than for gross misconduct, to continue Medical coverage for employees and/or their insured dependents for up to 18 months from the qualifying event. A spouse or child who loses coverage due to an employee's death, divorce, legal separation or entitlement to Medicare and a child who loses dependent status under the plan may elect continuation for up to 36 months. Any individual who is determined to be disabled under the Social Security Act at the time of termination or reduction of hours may extend coverage from 18 months to 29 months if the determination is provided before the end of the 18 month period. If the employee is no longer disabled, continuation of coverage shall terminate on the later date of 18 months or the month that begins more than 31 days after the date of final determination under Title II or Title XVI of the Social Security Act. An individual's Life, Accidental Death and Dismemberment, Dental, Disability Income, and Vision coverage may not be continued.

Group insurance benefits and premium rates for individuals on continuation are the same as those for active employees and dependents. The planholder may charge an additional 2% of premium as an administrative fee. For those individuals who are deemed disabled under the Social Security Act who extend coverage from 18 months to 29 months, the planholder may charge an additional 50% of premium for the 19<sup>th</sup> through the 29<sup>th</sup> month. Any change in benefits will apply to persons with continued coverage, provided they are not hospitalized at the time.

In order to retain insurance benefits an individual has 30 days from the qualifying event to elect to continue coverage in writing. A completed election form must be returned to the planholder. If it is not sent within 30 days from the qualifying event it is assumed the individual has elected not to continue under the group plan. The first monthly premium is due from the individual to the planholder within 30 days of the individual's written election to continue coverage.

Continued coverage will end on the earliest of the following events to occur: (1) the end of the period of continuation for which the individual is entitled; (2) the date upon which the employer ceases to provide any health benefits plan to any employee or other qualified beneficiary; (3) the expiration of the monthly period for which premiums have been paid, in the event of non-payment of premiums; (4) the date the individual becomes covered under a group plan which does not contain any exclusion or limitation with respect to a pre-existing condition of the person; (5) the date the person becomes entitled to Medicare.

In addition, you may exercise any Hospital and/or Medical conversion rights now or at the end of the continuation period. Life insurance conversion rights, if any, must be exercised within 31 days of termination from the group plan.

**PLEASE READ THE CERTIFICATE BOOKLET FOR ADDITIONAL INFORMATION**

- I do not elect to continue my group health benefits under the group plan.
- I elect to continue my group health benefits under the group plan and agree to the conditions and requirements outlined above.

Please continue coverage for:

- Employee  Spouse  Child(ren)
- Employee and Eligible Dependents  Spouse & Child(ren)

If you later wish to terminate your insurance, please notify the planholder in writing.

Signature of Person Making Election:	Date:
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Certified for Planholder by: (Name and Title)	Date:
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