



**HUMANA**

1100 Employers Boulevard  
Green Bay, WI 54344

## Continuation of Medical/Dental Benefits Election Form

Offered by **Employers Health Insurance Company**

**Subject to the terms stated in your Certificate,** Continuation of Medical/Dental benefits may be available for you and/or your covered Dependents. Please refer to the Certificate for terms and limitations. To apply for continuation of Medical/Dental benefits, please complete and return this form to your Employer (or previous Employer, in the event of termination of employment).

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Your Address: \_\_\_\_\_

Your Phone Number: ( ) \_\_\_\_\_

Check the qualifying event that applies to you and indicate the date of the qualifying event in the blank:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Termination.      | Last date employed: _____   | <input type="checkbox"/> Reduced hours.    | Date hours reduced: _____   |
| <input type="checkbox"/> Medicare.         | Date covered by Medicare: _____                                   | <input type="checkbox"/> Employee's Death. | Date: _____   |
| <input type="checkbox"/> Legal Separation. | Date Legal Separation Filed: _____                                | <input type="checkbox"/> Divorce.          | Date Divorce Effective: _____   |
| <input type="checkbox"/> Dependent Child.  | Date Dependent Child ceased<br>to be an eligible Dependent: _____ | <input type="checkbox"/> Other.            | (As stated in your Certificate<br>provision for State Continuation) _____ |

**Employer complete** premium due for coverages. Date form is given to insured \_\_\_\_\_

	Medical	Dental
Employee Only	_____ /Month	_____ /Month
Employee + Spouse	_____ /Month	_____ /Month
Employee + Child	_____ /Month	_____ /Month
Family	_____ /Month	_____ /Month

(Note: Rates are subject to any Employer changes to plan.) **PREMIUMS MUST BE PAID TO THE EMPLOYER.**

Timely payment of premiums required for the coverage to continue, for the premium due date for State Continuation, please refer to the Continuation provision in your Certificate.

For Federal Continuation, the initial premium is due within 45 days after the date Continuation of coverage is elected. Subsequent premiums are due monthly by the \_\_\_\_\_ of the month. If the Employer does not receive full payment within 31 days of the due date, your coverage will be canceled.

**SIGNATURE OF PERSON ELECTING OR WAIVING CONTINUATION:**  I elect continuation  
 I refuse continuation

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

Dependent: \_\_\_\_\_ Date: \_\_\_\_\_  
(Over Age 19)

### **SPOUSE AND DEPENDENT SIGNATURES ARE REQUIRED IF ANY DEPENDENT COVERAGES ARE BEING WAIVED.**

If the State Continuation provision applies, a completed form must be returned within 31 days of termination. If the Federal Continuation (COBRA) provision applies, a completed form must be returned within 60 days after or the later of: 1) the date that you would lose coverage, or 2) the date that you are sent notice of your right to elect Cobra Continuation. An election is considered to be made on the date that it is sent to your Employer or plan sponsor. Failure to return form within the specified time may result in the loss of the Continuation privilege.

NOTE: If you are deemed Totally Disabled by the Social Security Administration, send a copy of the notification to our company as you may be entitled to an additional 11 months of coverage. Please call us for more information.