

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:
Name of Person Making Election:	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:	Date of Birth:	Relationship to Employee:

Names of Continuing Eligible Dependents (If more space is needed please attach a separate sheet of paper)

Full Name: (Last, First, MI)	Sex:	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 York law permits an employee and eligible dependents whose group Hospital Surgical and/or Major Medical coverage ends due to termination of employment or membership in an eligible class to continue group health coverage for up to 18 months. An employee determined to be totally disabled under Title II or Title XVI of the Social Security Act at the time of termination, or within the first 60 days of continued coverage, may extend coverage for an additional 11 months. An eligible dependent whose coverage ends due to the death of the employee, divorce, legal separation or entitlement to Medicare, and a child who ceases to be a qualified dependent under the plan can continue coverage for up to 36 months. Continuation is not available to an individual who is covered by Medicare or other group health coverage unless the other coverage contains a pre-existing condition exclusion or limitation applicable to that person. Life, Accidental Death & Dismemberment, Dental, Vision, and Disability Income Insurance cannot be continued.

Group Hospital Surgical and/or Major Medical benefits and premium rates for persons 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. Any change in benefits will apply to persons on continuation.

In order to retain your group health benefits, you will be required to make monthly payments to the planholder of \$_____ for yourself and \$_____ for your dependents. This amount may change in accordance with any premium rate changes for the group plan.

In the event of divorce, legal separation, or a child who ceases to be a qualified dependent, the employee or dependent must notify the planholder within 60 days of the event. A disabled employee who wishes to extend coverage from 18 to 29 months must notify the employer within 60 days of the determination under Title II or Title XVI of the Social Security Act of total disability at the time of termination or within the first 60 days of continuation. The continuant must notify the planholder within 30 days if the continuant is determined to be no longer disabled.

The planholder must provide the terminating individual with a written election form and notification of continuation rights within 14 days. If this cannot be done in person, then the planholder must mail this form to the person's last known address. The completed form and the first monthly premium must be sent to the planholder within 60 days following the later of (1) the date coverage would otherwise terminate or (2) the date the individual is given notice of the right to continue by the planholder. Subsequent monthly premium must be sent to the planholder by the _____ day of each month. If an individual does not respond, it is assumed that continuation under the group plan is not elected.

Continued coverage will end when the first of the following events occurs; (1) the end of the period of continuation for which the individual is eligible; (2) the end of the period for which premium payments have been paid; (3) the date the group plan terminates and is not replaced; (4) the date the individual is ELIGIBLE for Medicare, or covered by other group health coverage that does not contain a pre-existing condition exclusion or limitation that would apply to the individual.

Life insurance conversion rights, if any, must be exercised within 31 days of termination of coverage. In addition, an individual may exercise any available hospital or medical conversion rights now or at the end of the continuation period.

PLEASE READ THE CERTIFICATE BOOKLET FOR ADDITIONAL INFORMATION

I do not elect to continue my insurance under the group plan.

I elect to continue my insurance under the group plan.

Please continue coverage for:

<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse (Surviving, Divorced, Legally Separated)
<input type="checkbox"/> Employee & Eligible Dependents	<input type="checkbox"/> Spouse & Children (Surviving, Divorced, Legally Separated)
	<input type="checkbox"/> Child(ren) (Other than child of terminated employee)

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

Signature of Person Making Election:	Date:
Certified For Planholder By: (Name and Title)	Date: