

Persons: _____
Date Received: _____

HEALTH CARE CONTINUATION ELECTION FORM
Pursuant to the Consolidated Omnibus Reconciliation Act of 1986 (COBRA)

(FOR GROUPS WITH 20 OR MORE EMPLOYEES)

Company Name: _____ Managed Benefits Administrator and Insurance Consultants, Inc. _____
Policy Case Number: _____

Please supply the names and addresses of ALL persons applying for continuation of coverage:

Name: _____
Address: _____
Relationship to Employee: _____ Date of Birth: _____ SS#: _____

Name: _____
Address: _____
Relationship to Employee: _____ Date of Birth: _____ SS#: _____

Name: _____
Address: _____
Relationship to Employee: _____ Date of Birth: _____ SS#: _____

Qualifying Event

The following event(s) caused me and/or the above named beneficiaries to lose group health coverage and qualifies me and/or the above named beneficiaries for continuation of health care coverage. (Please check only those Qualifying Events which apply):

- 1) Employment Terminated? (Use "Y" for Yes and "N" for No)
If Yes, was termination:
 Voluntary?
 Involuntary?
 Due to Strike?
 Due to Leave of Absence?
Date of Termination: _____
- 2) Reduction of Hours?
If Yes, please state:
 Number of Hours: _____
Date of Reduction of Hours: _____
- 3) Death of Employee? Date of Death: _____
- 4) Divorce or Legal Separation? Date of Divorce _____
or Legal Separation: _____
Date Entitled to Medicare: _____
- 5) Entitled to Medicare?
- 6) Dependent Child Ceases to Be Eligible Date Dependent Child _____
Ceases to Be Eligible: _____

(CHECK ONE)

- _____ I elect to continue coverage under the group health care benefits plan.
_____ I elect **not** to continue coverage under the group health care benefits plan.

I submit herewith the current premium due. I agree to remit additional monthly premiums no later than the Due Date day of each month. I understand that if I do not submit my monthly premium in a timely manner, my coverage may be terminated as of the date such premium was due.

I agree to remit within 45 days from the date of this election the premium due for coverage from the date of the above qualifying event to the date of this election. I understand that if I do not remit the required premiums within this time period, I will not be allowed to continue coverage.

I agree to notify **Merrill Bostrom Associates** if I become covered under any group health care plan or become eligible for Medicare benefits while on continued coverage.

Signature

Date

- Employee Spouse of Employee Dependent Child of Employee

THIS FORM MUST BE RETURNED TO EMPLOYER WITHIN 60 DAYS OF THE DATE SENT AS NOTED ABOVE.