

NOTICE OF RIGHT TO CONTINUE GROUP LIFE AND/OR MEDICAL/DENTAL COVERAGE

DATE:

TO:

MEMBERS ID#:

Your group life and medical/dental coverage would normally terminate as of _____. You may exercise your right to Individual Purchase as explained in your policy booklet. Or, State Law permits you to continue the group coverage (including dependent coverage) for up to 18 months, until the date the preexisting exclusion or limitation expires under the new group plan, or until the date this group plan terminates (and is not replaced), whichever is earliest (Individual Purchase is also available at the end of the continuation period, subject to the Individual Purchase Provisions of the group plan.)

If you decide to continue the group life and/or medical/dental coverage (either or both), please so indicate at the bottom of this form and return it to the firm listed below within **60** days after the date of this notice. It will then be your responsibility to pay the monthly premium of:

	Individual	Dependent
For life insurance; and/or dental	_____	_____
For medical insurance	_____	_____
Total	_____	_____

Check or money order made payable and sent to the firm listed below. The first payment must be returned with this form within the specified time limit; otherwise you will lose the right to continue coverage. Subsequent payments must be received in this office no later than the **1st** day of the month. Failure to make timely payments will be cause for termination of coverage.

(Authorized Signature)

(Firm's Name)

(Firm's Address)

(Group Account #)

(Date employment terminated)

(Or, date of reduction in hours)

Life insurance to be continued. Y e s _____ **N o** _____

Medical insurance to be continued. Y e s _____ **N o** _____

Dental insurance to be continued Y e s _____ **N o** _____

(Members signature)

(Address)

(Date signed)