TEMPORARY CONTINUATION OF GROUP MEDICAL AND DENTAL/OPTICAL COVERAGE
NOTIFICATION/APPLICATION

Federal law requires that the option to continue medical and dental coverage under an employer sponsored group health plan be given to an employee or dependent whose coverage ends due to a "qualifying event". "Qualifying event" means: (a) voluntary or involuntary termination (other than for gross misconduct) or reduction of hours of an employee's employment; or (b) the death of the employee; or (c) the divorce or legal separation of the employee; or (d) a dependent ceasing to be an eligible dependent; or (e) an employee becoming entitled to Medicare benefits.

The employer must send this notice to the employee or dependent after his coverage ends. If the employee or dependent wants to continue coverage, he must complete this form and return it to the employer not later than 60 days after he receives this notice. Insurance will continue at the covered person's expense. The monthly premium rate will be the same as the rate that would have been charged for such coverage had the covered person's coverage remained in effect (including any portion paid by the employer). Premiums are payable monthly in advance to the employer. Exception: for the initial premium payment, the covered person has up to 45 days after first electing continued coverage to pay the premium.

Coverage will continue until the earliest of: (a) 18 months after the employee's employment terminated or reduced in hours; or (b) 36 months after coverage terminated due to a qualifying event other than the employee's employment terminating or reducing in hours; or (c) the date the covered person is covered under another group insurance plan which does not have restrictions or exclusions to pre-existing conditions applying to the beneficiary(ies); or (d) the date the covered person is entitled to Medicare; or (e) the date the covered person fails to pay the premium when due; or (f) the date the employer ceases to provide a group health plan.

During the last 180 days of continued coverage, the covered person will be entitled to an individual plan of health coverage, if: (a) a conversion privilege is included under the group plan with respect to any Hospital, Surgical, Medical or Major Medical Coverage; and (b) the covered person is eligible for such plan. Contact Group Marketing Services, Inc. for details.

AFTER SECTIONS I AND II ARE COMPLETED, THE WHITE COPY OF THIS FORM SHOULD BE SENT TO GROUP MARKETING SERVICES, INC. THE PINK COPY SHOULD BE GIVEN TO THE EMPLOYEE OR DEPENDENT. THE YELLOW COPY SHOULD BE KEPT IN THE EMPLOYER'S FILE.
If applying for continuation of coverage, Form #489J must accompany this form.

SECTION I: TO BE COMPLETED BY THE EMPLOYER

Group Policy Number | Name of Employer | **Authorized Employer Signature**

Complete, Print, Sign and Mail Form to COBRA Applicant(s)

Address of Employer

Full Name and Home address of Employee/Dependent | Qualifying Event | Date Group Coverage Terminated

Month Day Year

The employee was insured for: [ ] Medical Only [ ] Medical and Dental/Optical

[ ] Employee Coverage Only [ ] Employee and Dependent Coverage Including ( ) Spouse ( ) Children

Monthly Premium | Date 1st Payment is Due: (**45 Days from Election**)

Health $ | Dental/Optical $ | Thereafter Premium is Due: (**1st**) each month

SECTION II: TO BE COMPLETED BY THE APPLICANT

[ ] I want to continue [ ] Medical [ ] Medical and Dental/Optical Insurance

Insurance Continuation is for:

[ ] Employee Coverage; [ ] Spouse Coverage; [ ] Spouse and Children Coverage; [ ] Children Coverage

Applicants Social Security No. _____ Applicants Date of Birth _____

I will pay the premium shown above under Section I to the Employer.

[ ] My first payment is enclosed. [ ] You will receive my first payment within 45 days

[ ] I do not want to continue my group [ ] Medical [ ] Medical and Dental/Optical Insurance

Complete, Print, Sign and Mail Form to PO Box 19040 Kalamazoo. MI 49019

Date Signed | Signature of Applicant

Please keep this with your Certificate/Booklet. If you need claim forms, please contact the Employer named above.

(COBRA Form #87) 11/93