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 **2012**

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

ELECTION ENROLLMENT INFORMATION

TEMPORARY CONTINUATION OF GROUP MEDICAL AND DENTAL/OPTICAL COVERAGE

This Form must accompany COBRA Form #87 GMS 12/87 when making application for continuation of coverage.

SECTION I: Election Information

EMPLOYEE ELECTION - As a covered employee who has lost or will lose coverage under my employer sponsored health plan resulting from a qualifying event, I choose to elect continued coverage as indicated:

☐ Myself only ☐ Myself and dependents ☐ Dependents only X _____

Your Signature Date

QUALIFIED BENEFICIARY ELECTION ☐ YES, as a qualified beneficiary who has lost or will lose coverage as the result of a qualifying event, I choose to elect continued coverage.

A qualified beneficiary is a spouse or dependent, not an EMPLOYEE, who has or will lose coverage due to a qualifying event. X _____

Your Signature Date

* An election by the spouse may consitute election for all dependents living with the spouse at the time of the event.

** A dependent child who ceases to be a dependent as defined under the health plan must indivually elect, except in the case of a minor.

INITIAL PREMIUM CALCULATION (Example Only)

- Initial premium payment MUST include ALL 30 day periods which have elapse since your coverage terminated PLUS the current month for which you have elected coverage.
- If you terminated coverage January 1, elected continuation coverage February 28, made first payment March 10, your 1st payment must allow for (3) months coverage. (Jan. 1 - Feb. 1, Feb. 1 - Mar. 1 (elapsed period) plus Mar. 1 - Apr. 1 (current month) the next premium would be due April 1 to cover April 1 - May 1.

SECTION II: Enrollment Information

EMPLOYER PLAN | EMPLOYEE | SOCIAL SECURITY NO.

EMPLOYER ADDRESS | CITY, STATE, ZIP | PHONE

SPOUSE | DATE OF BIRTH | SOCIAL SECURITY NO.

SPOUSE ADDRESS (If different) | PHONE

NAME(S) OF ELIGIBLE DEPENDENTS	DATE OF BIRTH	INDICATE WHICH APPLIES	
		FULL-TIME STUDENT	LIVES AT HOME**

**Give Address If Not Living At Home

ANSWER THE FOLLOWING QUESTIONS:

A) Are you or any of your dependents eligible for Medicare coverage? ☐ YES ☐ NO If Yes, list _____

B) Are you or any of your covered dependents employed? ☐ YES ☐ NO If Yes, list their names and employers.

C) Are you or any of your covered dependents covered under any other health coverage? ☐ YES ☐ NO If Yes, list source of coverage and when coverage began: _____

I certify all of the above information to be true and correct to the best of my knowledge and to comply and conform to all normal plan provisions. I agree to reimburse the plan any and all benefits paid to me, my dependents or to any other party on my behalf, if it is determined I or my dependent(s) were not entitled to such benefits.

Signature Date