FOR GROUPS WITH 20 OR MORE EMPLOYEES

CONTINUATION ELECTION FORM FOR SMALL GROUP HEALTH COVERAGE

(Does not apply to Life, AD&D and/or Disability Coverage)

As an individual who is no longer eligible for coverage as a result of a **QUALIFYING EVENT**, you have the right to elect continuation of your group health coverage only under Group Name_____Group Number _____. Group health coverage includes only your major medical and dental coverage, if a part of your plan.

A QUALIFYING EVENT is:

(a) death of an employee;
(b) an employee's termination of employment (other than for gross misconduct) or reduction of hours worked;
(c) a divorce or legal separation;
(d) the covered employee becoming entitled to Medicare benefits; or
(e) a dependent child ceasing to qualify as a dependent under the plan.

If you wish to continue or not to continue your health coverage, it is your responsibility to complete and return this form to us as soon as possible. If you elect to continue health coverage the applicable premium must be given to your employer in order for us to be able to bill your monthly premium.

Coverage will be continued until the earliest of the following:

(a) Maximum of 18 months for the employee's termination or reduction of hours. Maximum of 36 months for any other **QUALIFYING EVENT**.
(b) The date any premium is due and not paid.
(c) The date the master policy ends.
(d) The date the employer withdraws from the health plan or fails to remit the group premium on a timely basis.
(e) The date the continuee, after election, is covered by any other group health plan or is entitled to Medicare benefits.

MUST BE COMPLETED FOR EACH TERMINATED INDIVIDUAL

❑ I elect to continue my group Health coverage. ❑ I elect to continue my group Dental coverage.

❑ I elect not to continue my group health coverage. ❑ I elect not to continue my group Dental coverage.

MUST BE COMPLETED BY EMPLOYER

Employee Name _____Soc. Sec. No._____

or Dependent_____DOB _____Soc. Sec. No._____

Date last worked or date of **QUALIFYING EVENT** _____

QUALIFYING EVENT or reason for termination _____

Number of **FULL-TIME AND PART-TIME** employees_____

Premium Due (H&A premium only from Group Billing)_____

Employer's Signature _____Date _____

MUST BE COMPLETED BY EMPLOYEE OR DEPENDENT, IF APPLICABLE

Home Address: Street _____

City _____State _____Zip _____

List eligible individuals to be insured:

_____

_____

_____

Employee or dependent signature _____ Date_____

Return form to:

Triple Choice Plan
3030 South Bundy Drive
Los Angeles, CA 90066

TRIPLE CHOICE PLAN
EXCLUSIVE DENTAL PACKAGES

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