REQUEST FOR MEDICAL, DENTAL, AND/OR VISION CONTINUATION GROUP PLANS

Note to employers: An employer may not offer continuation coverage in the event that the employer terminates the employee upon a finding of gross misconduct.

RESET FORM

APPLICANT INFORMATION

Employee name: _____ Social Security number (last four digits): _____

Mailing address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Email address: _____

Employer name: _____ Employer number: _____

Request medical continuation for*: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent(s) only

Request dental continuation for*: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent(s) only

Request vision continuation for*: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent(s) only

***This provision is only available if your employer elects it.**

If continuation is for a dependent only, complete the following:

Dependent name: _____ Birth date: _____

Dependent Social Security number (last four digits) _____ Telephone number: _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Last day of full-time eligibility for coverage: _____

Eligibility for medical, dental, and/or vision coverage ceased because: _____

Last Date of Continuation of Coverage if less than maximum eligible period described below (coverage ends at 11:59 p.m. on the date listed): _____

I understand that this request must be made within 60 days of the date my Group Plans medical, dental, and/or vision plan terminates. I further understand that this request, if approved, will permit me (and my eligible dependents, if applicable) to continue participation in the Group Plans medical, dental, and/or vision plan for not more than 18 or 36 months (depending on the reason(s)* for termination of coverage) after the date I became ineligible for medical, dental, and/or vision coverage. I understand that I become ineligible for medical continuation coverage when I become Medicare eligible. I understand that dependent only continuation coverage will be charged at the Employee or Employee + Child rate.

*18 Months

- Termination of employment
- Loss of coverage due to reduction in the number of hours worked
- Elimination of eligible class of employees

* 36 Months

- Divorce or legal separation from employee
- Loss of dependent child status (e.g., children who reach the maximum age limit under the plan)

I agree to promptly notify the above-named employer if I become covered as an employee or dependent under another group medical, dental, and/or vision plan. I further understand all other coverage will cease (or ceased) on the date I became ineligible for such coverages.

AUTHORIZED SIGNATURES

Applicant's signature: _____ Date: _____

Employer's Authorized Representative signature: _____ Date: _____

Email to: *Group.Insurance@GuideStone.org**
***This is an unmonitored inbox for form submission ONLY.**

GuideStone®

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