Request for Medical, Dental and/or Vision Continuation
The Evangelical Alliance Mission

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): _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Telephone number: (_____) _____ Email address: _____

Employer name: The Evangelical Alliance Mission Employer number: 71061

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

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 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 months 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.

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

Applicant's signature: _____ Date: _____/_____/_____

Employer's authorized representative: _____ Date: _____/_____/_____

Email to: *Benefits@Team.org*

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