## Request for Special Medical 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.

nployee name: Social Security number (last four digits):				
Street address:				
City:	State:	ZIP Code:		
Telephone number: ()	_ Email address:			
Employer name:	Employer num	ber:		
Request special medical continuation for*:   Employee only	☐ Employee and spouse	$\square$ Spouse only		
*This provision is only available if your employer elects it.				
If continuation is for a spouse only, complete the following:				
Spouse name:		Birth date:	/	/
Spouse 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 and/or dental coverage ceased because: _				
Last Date of Continuation Coverage if less than maximum eligib	le period described below (cove	erage ends at 11:59 p.m. o	on the date	listed):
I understand that this request must be made within 60 days of the that this request, if approved, will permit me (and eligible spou the date I reach Medicare eligibility (last day of the month befo continuation coverage when I become Medicare eligible. I under rate. Special Medical Continuation is applicable in these scenario	se, if applicable) to continue pare sixty-fifth birthday). I underserstand that spouse only contin	articipation in the Group stand that I become ineli	Plans med gible for sp	ical plan un ecial medic
Employer does not offer retiree coverage and employee is ret	iring between the ages of 55-64	and is not eligible for Me	edicare.	
<ul> <li>Retiring at 65+ years old and spouse is not yet 65 and not eligiturn 65.</li> </ul>	ble for Medicare. Spouse is elig	gible for Special Medical	Continuatio	on until they
<ul> <li>Still an active employee over age 65 but waiving out of emplo care, they are eligible for Special Medical Continuation until the</li> </ul>		e. If spouse is under 65 ar	nd not eligil	ble for Medi
I agree to promptly notify the above-named employer if I become dental plan. I further understand all other coverage will cease (or				edical and/
Applicant's signature:		Da	ate:/_	/
Employer's authorized representative:		Da	ate:/	/



