GROUP COVERAGE CONTINUATION ELECTION FORM

PacificSource Health Plans
Membership Department
PO Box 7068
Springfield, OR 97475-0068

(For Washington groups that have elected to offer state continuation)

- This form is to be completed whether you apply for continuation coverage or decline continuation coverage.
- **To continue coverage,** complete all sections. **To decline coverage,** complete only sections 1, 2, and 6.
- Return the completed form to PacificSource within 31 days after the last day of coverage under the plan, or within 10 days of receipt of this letter, whichever is later.

Please type or print in ink.

SECTION 1 QUALIFYING INDIVIDUAL INFORMATION

Last Name	First	M.I.	Social Security No.		Group No.
Street Address	City		State	Zip Code	Daytime Phone No.
Date of Birth	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married/Registered Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed			

SECTION 2 QUALIFYING EVENT INFORMATION

I am eligible for continuation of benefits because I lost coverage under the terms of my group health plan due to (check one):

☐ Termination of employment or reduction in hours
☐ Divorce or Dissolution of Domestic Partnership from a covered employee – Date of event:_____
☐ Covered dependent no longer meets eligibility requirements – Date of event:_____
☐ Death of a covered employee

Is anyone applying for continuation covered by other group insurance? ☐ Yes ☐ No

If yes, name of insured:_____ Insurance carrier:_____

If you are not the covered employee, give name and Social Security number of employee who is primary on the policy:

Name:_____ Social Security No.:_____

SECTION 3 CONTINUATION PREMIUM RATES

After you enroll, each premium payment must be received by the employer **before the first day of each month** for which you wish to continue coverage. A grace period of 30 days will be granted for the payment of each premium. Your coverage will be cancelled if the employer does not receive your premium on time. You may continue any coverage you had before the qualifying event listed in section 2. Ask your employer if you have questions about this coverage.

	Employee Only	**Employee + Spouse/Registered Domestic Partner**	**Employee + Family**	**Employee + Children**
Premium:	$	$	$	$

SECTION 4 DEPENDENTS CONTINUING COVERAGE

Please list all dependent family members continuing coverage.
If space is needed for additional dependents, use the back of this form or a separate sheet.

	Last Name	First Name	M.I.	Birth Date	Sex	Relationship
1						
2						
3						
4						
5						
6						

SECTION 5 TYPE OF COVERAGE YOU ARE ELECTING

Please indicate your choice of coverage and your family's participation level. Please note:

- **You** may continue the type of coverage you had (or currently have).

For covered employee: ☐ Medical*

For dependent #1 (named in section 4): ☐ Medical

For dependent #2 (named in section 4): ☐ Medical

For dependent #3 (named in section 4): ☐ Medical

For dependent #4 (named in section 4): ☐ Medical

For dependent #5 (named in section 4): ☐ Medical

For dependent #6 (named in section 4): ☐ Medical

*The Medical plan does not have pediatric dental coverage. You will need to obtain it through another plan in order to be compliant with ACA.

SECTION 6 SIGNATURE OF QUALIFYING INDIVIDUAL

ACCEPT: I have read and understand the notification of rights on the reverse side. I hereby **request** continued coverage as indicated above. I understand that failure to make timely payment of required premiums will result in permanent loss of this coverage. While under coverage I expressly authorize any licensed physician, hospital, insurance company, or person that has any record or knowledge of my health or the health of any listed family member to furnish to PacificSource with any records concerning myself or any family member named on this application for the purpose of collecting information in connection with a claim for benefits. A photographic copy of the authorization will be as valid as the original.

_____ _____

Signature Date

DECLINE: I have read and understand the notification of rights to continue health coverage on the reverse side. I hereby **decline** continued coverage available to me as a result of the qualifying event indicated above.

_____ _____

Signature Date

Please see next page for important information.

NOTIFICATION OF RIGHT TO CONTINUE GROUP HEALTH COVERAGE

Qualifying Events and Continuation Period

To be eligible for continuation coverage, an employee must have been insured under the employer's PacificSource group health insurance policy for at least the last three continuous months, and the member must experience a qualifying event that causes a loss of coverage under the terms of the group health insurance policy. If your employer changed health insurance plans or carriers during that time without a break in coverage and you were enrolled in your employer's plan continuously for the last three months, you will be eligible. An employee that has been covered under the employer's policy for less than three months, or has had a break in coverage during the last three months is not eligible for continuation.

Each covered person or qualified beneficiary (Employee, Spouse/Registered Domestic Partner, or dependent Child) may elect continuation together or separately.

Qualifying Event	***Continuation Period***
Employee's termination of employment or reduction in hours	Employee, Spouse/Registered Domestic Partner, and children may continue for up to three months
Employee's divorce or dissolution of domestic partnership	Spouse/Registered Domestic Partner and children may continue for up to three months
Employee's eligibility for Medicare benefits	Spouse/Registered Domestic Partner and children may continue for up to three months
Employee's death	Spouse/Registered Domestic Partner and children may continue for up to three months
Child no longer qualifies as a dependent	Child may continue for up to three months

When Coverage Ends

Your continuation coverage will end before the end of the three-month maximum continuation period listed above if any of the following occurs:

- Your continuation premium is not paid on time;
- You become covered under another group health plan;
- You become eligible for Medicare benefits;
- The group discontinues its health plan and no longer offers a group health plan to any of its employees.

Plan Changes or Termination

While it does not currently intend to do so, your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage. If your employer terminates the health plan, your continuation coverage will also terminate.

Enrollment Deadline

To continue coverage, this form must reach PacificSource within 31 days after your last day of coverage under the group policy, or within 10 days after you receive notification of your continuation rights, whichever is later. If your continuation election form is not returned by the deadline, your coverage will end on the last day you were eligible under the group health policy.

Dependent Coverage

To include your eligible dependents, you must list your family members in Section 4 on page 1 of this form. If your dependents were not covered prior to the qualifying event, they may not enroll in the continuation coverage at this time. Only newborn or newly adopted children may enroll in the continuation coverage after the qualifying event.

Premium Payments for Continued Coverage

The cost of continuation coverage is your responsibility. You must pay your premium to your former employer before the first day of each month for which you want coverage. The employer will include your continuation premium with the group's monthly payment to PacificSource. PacificSource cannot accept premium directly from you. If your premium is not paid on time, your coverage will end. If your coverage is cancelled due to a missed payment, it will not be reinstated for any reason. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.