Continuation Election Form

To _____
(name of employer)

I _____ whose Social Security
(name of employee)

number is _____ have been
(number)

terminated as an employee on _____.
(date of termination)

Before termination I was covered under the employer's group health insurance contract (check one)

____ for myself.

____ for myself and dependents.

I elect to have this coverage continue in force and I agree to pay the required premium.

Date of Application: _____

Signature of Insured: _____

Mailing Address: _____