Notice of Right to Elect State Continuation Coverage
(Termination or Reduction in Hours of Employment)

Date of Notice: _____

TO:	(Employee*)	
	(Address)	
	(City, State, Zipcode)	
FROM:	(Plan Administrator)	
	(Address)	
	(Telephone #)	

* Provide a copy to the employee's spouse and/or dependents, if any.

The Plan Administrator of the company's group health plan was notified that your group health coverage, and that of your spouse and dependent children, if any, will terminate due to the following event:

_____ Termination of employment
_____ Reduction in hours of employment

According to the State Regulation Section 38-71-770, this is a qualifying event that entitles you, your spouse and dependent children, if any, to elect to continue coverage under the plan for up to 6 months from the date of your qualifying event.

ELECTING CONTINUATION COVERAGE

You must complete and submit the attached election form to the Plan Administrator by: _____. This date is 60 days from the date of this notice.

This same notice is being sent separately to your spouse, if any. You or your spouse may make an election on behalf of all covered family members on the plan. State Continuation does, however, provide you the right to elect coverage independently for you, your spouse and children. You can elect to discontinue for certain family members.

PREMIUM PAYMENT

The current premium for your health care coverage and date when premium is due are explained on the election form. The premium may change in the future.

LENGTH OF COVERAGE

Provided you elect coverage, your coverage will last up to 6 months from the date of your qualifying event. The period may not be extended upon occurrence of the following events:

- Death of employee, divorce, legal separation or change in dependent status.
- Employee's entitlement to Medicare.
- Disability before, at, or within 60 days of the qualifying event, provided the Plan Administrator is notified within 60 days of the determination date of the disability.
- Employer bankruptcy filing.

TERMINATING CONTIUATION COVERAGE

Coverage for you and any dependents may terminate early under the following circumstances:

- Required premium payment is not paid when due.
- You become covered under another group health plan that does not limit or exclude coverage for your pre-existing conditions.
- You become entitled to Medicare benefits.
- The company's group health plans terminate.

State Continuation coverage is provided based on your eligibility. The Plan Administrator reserves the right to terminate your coverage retroactively if you are determined to be ineligible for coverage. You should keep your Plan Administrator informed of any address changes to ensure you and your dependents receive necessary information concerning your rights. This notice is only a summary of your State Continuation rights. Contact the Plan Administrator with specific questions.

State Continuation Coverage Election Form
(Termination or Reduction in Hours of Employment)

Date: _____

__X__ Mailed
_____ Hand Delivered

QUALIFIED BENEFICIARY INFORMATION

First Name M.I. Last Name Social Security #

Home Address City State Zipcode

Date of Birth Marital Status

# of Dependent Children Date of Hire

Policy Number

ENTITLEMENT TO STATE CONTINUATION COVERAGE

Please review the notice of State Contination rights accompanying this form. You, your spouse and dependent children, if any, could be entitled to continue health coverage under the company's group health plan due to the following qaulifying event, effective on _____.

_____ Termination of employment
_____ Reduction in hours of employment

This qualifying event will result in a loss of group health coverage unless you elect continuation coverage. If you would like to elect continuation coverage, please read and sign this form and return it to the address below as soon as possible.

You will lose your right to State continuation coverage and your coverage will terminate under the company's group health plan if this election form is not completed and returned within 60 days from the date of this notice.

Coverage is provided based on your eligibility. The Plan Administrator reserves the right to terminate your coverage retroactively if you are determined to be ineligible for coverage.

LENGTH OF COVERAGE

You, your spouse and any dependent children are eligible for up to 6 months of State continuation coverage from the date of the qualifying event. Coverage may be extended if you are disabled.

PREMIUMS

You must pay the initial premium within 45 days of your election to take State continuation coverage. The premium covers the period of coverage from the date of your qualifying event and any regular monthly premium that became due between your election and the end of the 45-day period.

Upon receipt of this election form by the Plan Administrator, you will be notified of the amount of your initial premium. Coverage may terminate if you fail to pay the initial premium and any subsequent monthly premiums in a timely fashion.

Your premium payments are due within 30 days after the first day of each month of coverage. Premiums may change. If so, you will be notified of any changes.

You are eligible for the following coverage: (Check one.)

_____Employee Only
_____Employee & Spouse
_____Employee & Children
_____Family

This coverage will be continued for you unless you specify otherwise.

The premuim for monthly State continuation coverage are as follows:

_____Employee Only
_____Employee & Spouse
_____Employee & Children
_____Family

COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED IF PREMIUM PAYMENT IS NOT RECEIVED ON TIME.

State Continuation Election Agreement

I have read and understand this form and my State continuation election rights. I realize that if I elect continuation coverage and fail to pay the required premium on time, this coverage will terminate. I agree to notify the Plan Administrator if I, or any covered family member, become(s) entitled to Medicare or covered under another group health plan.

CHECK ONE

_____ I elect to continue family coverage under the plan.

Dependents covered

Relationship	Name	Date of Birth

_____ I elect to continue single coverage under the plan.

_____ I have read this form and understand my State continuation rights. I waive my right to State continuation coverage under the plan.

Signature _____

Please print your name _____

Date _____

Address _____

Telephone _____

Send this form to: (Plan Administrator name) _____

(Plan Administrator address) _____

(Plan Administrator telephone) _____

For internal use only
Received by Plan Administrator (initials) ____
Date _____