DIOCESE OF DALLAS EMPLOYEE BENEFIT PLAN
NOTICE TO A QUALIFIED INDIVIDUAL
NOTICE OF YOUR RIGHT TO CONTINUE COVERAGE

On _____________*, your benefits under the Diocese of Dallas Employee Benefit plan terminated. However, you may continue medical and dental coverage under the plan for yourself and any dependents that were covered prior to _____________*. Coverage may be continued up to eighteen (18) months provided you and/or such dependents do not become covered under any other group health care plan.

You have (30) days from your termination date to decide whether or not you want to enroll for this continuation of coverage.

What it costs you to continue coverage?

If you choose to continue medical and dental coverage under the plan, a monthly payment of $__________ is required. Payment is due in advance on the first day of each month for which coverage is to be continued, or your coverage will end.

In addition, payment for the coverage provided from your termination date to the date you enroll is due no later than ten (10) days from the date you enroll.

When does your coverage end?

Continuation of coverage for any persons will end:

- If the monthly payment required to continue coverage is not made on or before the due date; or
- When a covered person becomes covered under another group health care plan; or
- The (18) month maximum is met and the plan terminates; or
- The plan itself terminates.

Continued coverage is continued monthly and will terminate on the last day of the month that your last payment is received.

When a person whom is on Continuation of Coverage becomes eligible for Medicare the continued coverage automatically becomes secondary to Medicare.

What you must do to continue coverage?

If you choose to continue coverage, complete the Continuation of Health Insurance Coverage form. Please return the form to your entity's business office and with a check payable to your entity within ten 30 days of your termination date.

You will **not** receive an invoice for each month's premium.

If you elect **NOT** to continue coverage, please check the box at the bottom of the Request Form, sign the form and return the form to your employer.

If you elected a Flexible Spending Account you may continue in that program for the remainder of the calendar year.

If you elected supplemental voluntary insurance you have an option to convert to an individual term life insurance policy. You may call Aetna customer service at 1-800-523-5065 or go to Aetna's website at www.aetna.com for additional details.

* Date of termination of benefits.

Roman Catholic Diocese of Dallas

Continuation Of Health Insurance Coverage Form

Please Print!

Name: ______________________________ **SS#**____________________

Entity Location Code: ________________

Name of Applicant(s)

First Middle Last	Date of Birth	Social Security Number
Member:		
Spouse:		
Child(ren):		

Member's Mailing Address:

Number, Street and Apt	City	State	Zip Code

Please return completed form and payment to your entity's business office within 30 days of your termination date.

***Your elected coverage will be continued from ____________ to _____________.
(Month/Day/Year) (Month/Day/Year)

○ **I elect not to continue coverage**

____
Member's Signature and Date Submitted

Business Offices, please fax completed forms to: (214) 379 3224