DIOCESE OF DALLAS EMPLOYEE BENEFIT PLAN
NOTICE TO A QUALIFIED INDIVIDUAL

NOTICE OF YOUR RIGHT TO CONTINUE HEALTH COVERAGE

On _____*, your benefits under the Diocese of Dallas Employee Benefit group 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 will it cost you to continue coverage?

If you choose to continue medical and dental coverage under the plan, a monthly payment of $_____for medical and $_____for dental 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 person 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
- When the (18) month maximum coverage is met; or
- When the plan itself terminates

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

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

What must you do to continue coverage?

If you choose to continue coverage, complete this Continuation of Health Insurance Coverage form. Please return the form to your entity's business office along with a check payable to your entity within 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 supplemental voluntary insurance you have an option to convert to an individual term life insurance policy. You may call UNUM customer service at 1-800-442-0915 or go to UNUM's website at www.unum.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 Name or Code: _____

Name of Applicant(s)

First M.I. 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.

- **I elect to Continue coverage from** _____ to _____.
  (Month/Day/Year) (Month/Day/Year)

- **I elect not to continue coverage**

_____ _____
Member's Signature and Date Submitted

Please only fax those that elect to continue coverage to (214) 379-3224.
Please keep the forms on file at your entity for those who elect NOT to continue coverage.

Revised: 5.24.2016