## INTERNATIONAL REQUEST FOR MEDICAL, DENTAL, AND/OR VISION CONTINUATION — GROUP PLANS

Note to employers: An employer may not offer continuation coverage in the event that the employer terminates the employee upon a finding of gross misconduct.

APPLICANT INFORMATION	
Employee name:	Social Security number (last four digits):
Street address:	
City:	State: ZIP code:
Telephone:	Email address:
Employer name:	Employer number:
Request medical continuation for*:	☐ Employee and dependent(s) ☐ Dependent(s) only
Request dental continuation for*:	☐ Employee and dependent(s) ☐ Dependent(s) only
Request vision continuation for*:	☐ Employee and dependent(s) ☐ Dependent(s) only
*This provision is only available if your employer ele	ects it.
Last day of employee's full-time eligibility for coverage: _	
Eligibility for medical, dental, and/or vision coverage cea	sed because:
If continuation is for a dependent only, complete the follow	ving:
Dependent name:	Dependent Social Security number (last four digits):
Dependent name:	Dependent Social Security number (last four digits):
Dependent name:	Dependent Social Security number (last four digits):
Dependent name:	Dependent Social Security number (last four digits):
Employees may transfer coverage to another plan offere is requested.	ed to their classification. Please write the name of the plan below, if a change
I further understand that this request, if approved, will pe the Group Plans medical, dental, and/or vision plan for n	ays of the date my Group Plans medical, dental, and/or vision plan terminates. rmit me (and my eligible dependents, if applicable) to continue participation in ot more than 18 or 36 months (dependent on the reason(s)* for termination of dental, and/or vision coverage. I understand that dependent only continuation + Child rate.
*18 Months	*36 Months
<ul> <li>Termination of employment</li> <li>Loss of coverage due to reduction in the number of hours worked</li> <li>Elimination of eligible class of employees</li> </ul>	<ul> <li>Divorce or legal separation from employee</li> <li>Loss of dependent child status (e.g., children who reach the maximum age limit under the plan)</li> </ul>
	r if I become covered as an employee or dependent under another group nd all other coverage will cease (or ceased) on the date I became ineligible
Employee signature:	Date:
Employer's Authorized Representative signature:	Date:

