



Enrollment Form for Continuation of Group Health Coverage (COBRA)

As an individual who is no longer eligible for coverage as a result of a "Qualifying Event" you have the right to elect continuation of your NCSMIG group health coverage.

Group health coverage includes medical, dental and vision, as part of your plan.

A "Qualifying Event" is:

1. Death of an employee.
2. An employee's termination of employment (other than for gross misconduct) or a reduction of hours worked.
3. A divorce or legal separation.
4. The covered employee becoming entitled to Medicare benefits.
5. A dependent child ceasing to qualify as a dependent under the plan.
6. Retirement

If you wish to continue or discontinue your health coverage, it is **your responsibility** to complete and return this form.

If you elect to continue health coverage, you must pay the premium by the due date set by your school district each month following the "qualifying event." Contact your school district's payroll department to obtain the applicable premium amount and send it to your payroll department, by the due date, with this form.

MUST BE COMPLETED BY EMPLOYEE, OR DEPENDENT, OR LEGAL GUARDIAN

Employee Name: _____ SS# _____

Home Address: Street _____
City _____ Zip _____

Qualifying Event:

- | | | |
|---------------------------------------------|--------------------------------------------------------|--------------------------------|
| <input type="checkbox"/> Termination | <input type="checkbox"/> Death of Employee | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reduction in Hours | <input type="checkbox"/> Divorce or Separation | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Loss of dep child eligibility | |

Date of event: _____ Date of loss of coverage: _____

- I wish to discontinue coverage at this time
 I wish to continue coverage at this time Specify: Medical Dental Vision

List all eligible individuals to be insured: Employee _____
 Dependent _____ DOB _____ SS# _____
 Dependent _____ DOB _____ SS# _____
 Dependent _____ DOB _____ SS# _____

Employee Signature: _____ Date: _____

RETURN FORM TO: School District Payroll Department, within 60 days of receipt of this form.

District Representative Signature

Date

DISTRICT USE ONLY:

Spouse/Dependents notified: _____

Date

Last Day to Enroll