HUMANA®
1100 Employers Boulevard
Green Bay, WI 54344

Continuation of Medical/Dental Benefits Election Form

Subject to the terms stated in your Certificate, Continuation of Medical/Dental benefits may be available for you and/or your covered Dependents. Please refer to the Certificate for terms and limitations. To apply for continuation of Medical/Dental benefits, please complete and return this form to your Employer (or previous Employer, in the event of termination of employment).

Employer Name: ______________________ Group Number: ______________

Employee Name: ______________________ Social Security Number: ______________

Dependent Name: ______________________ Social Security Number: ______________

Your Address: ____

Your Phone Number: (   ) ______________________

Check the qualifying event that applies to you and indicate the date of the qualifying event in the blank:

❑ Termination. Last date employed: _______
❑ Medicare. Date covered by Medicare: _______
❑ Legal Separation. Date Legal Separation Filed: _______
❑ Dependent Child. Date Dependent Child ceased to be an eligible Dependent: _______
❑ Reduced hours. Date hours reduced: _______
❑ Employee's Death. Date: _______
❑ Divorce. Date Divorce Effective: _______
❑ Other. (As stated in your Certificate provision for State Continuation) _______

Employer complete premium due for coverages. Date form is given to insured ____________

	Medical	Dental
Employee Only	____________ /Month	____________ /Month
Employee + Spouse	____________ /Month	____________ /Month
Employee + Child	____________ /Month	____________ /Month
Family	____________ /Month	____________ /Month

(Note: Rates are subject to any Employer changes to plan.) **PREMIUMS MUST BE PAID TO THE EMPLOYER.**

Timely payment of premiums required for the coverage to continue, for the premium due date for State Continuation, please refer to the Continuation provision in your Certificate.

For Federal Continuation, the initial premium is due within 45 days after the date Continuation of coverage is elected. Subsequent premiums are due monthly by the _______ of the month. If the Employer does not receive full payment within 31 days of the due date, your coverage will be canceled.

SIGNATURE OF PERSON ELECTING OR WAIVING CONTINUATION:

❑ I elect continuation
❑ I refuse continuation

Employee: ______________________ Date: ______________

Spouse: ______________________ Date: ______________

Dependent: ______________________ Date: ______________
(Over Age 19)

SPOUSE AND DEPENDENT SIGNATURES ARE REQUIRED IF ANY DEPENDENT COVERAGES ARE BEING WAIVED.

If the State Continuation provision applies, a completed form must be returned within 31 days of termination. If the Federal Continuation (COBRA) provision applies, a completed form must be returned within 60 days after or the later of: 1) the date that you would lose coverage, or 2) the date that you are sent notice of your right to elect Cobra Continuation. An election is considered to be made on the date that it is sent to your Employer or plan sponsor. Failure to return form within the specified time may result in the loss of the Continuation privilege.
NOTE: If you are deemed Totally Disabled by the Social Security Administration, send a copy of the notification to our company as you may be entitled to an additional 11 months of coverage. Please call us for more information.

Life And/Or Medical Conversion Election Form

Subject to the terms stated in your Certificate, if your coverage under the Policy terminates, you and/or your covered dependents may be eligible for a Conversion Policy. Please refer to your Certificate for terms and limitations. An application may be obtained by completing this form and returning it within 31 days from your termination date, or as otherwise stated in your Certificate. If we do not receive it in 31 days, you may lose your Conversion privilege. Upon receipt of this form, we will verify eligibility and notify you if you are or are not eligible to convert your coverage. **Return this form to: Humana Inc., 1100 Employers Blvd, Green Bay, WI 54344 or call 1-800-558-4444.**

Group Number: ______________________

Employee Name: ______________________ Social Security Number: ______________

Dependent Name: ______________________ Social Security Number: ______________

Your Address: ____

Your Phone Number: ( ) ______________________ County of Residence: ______________

Check the qualifying event that applies to you and indicate the date of the qualifying event in the blank:

- ❑ Termination. Last date employed: ________
- ❑ Medicare. Date covered by Medicare: ________
- ❑ Legal Separation. Date Legal Separation Filed: ________
- ❑ Dependent Child. Date Dependent Child ceased to be an eligible Dependent: ________
- ❑ Reduced hours. Date hours reduced: ________
- ❑ Employee's Death. Date: ________
- ❑ Divorce. Date Divorce Effective: ________
- ❑ Other. (As stated in your Certificate provision for State Continuation) ______

I refuse all Conversion options available to me. __________

I elect to Convert the following coverages. __________

MEDICAL: *Employee Only Coverage:* __________ *Family Coverage:* __________

1. List below all other medical insurance policies under which you are currently covered:

Name of Insurance Company	Policy Number	Phone Number
		( )
		( )
		( )
		( )

2. Are you currently covered by: ❑ Medicare Part A ❑ Medicare Part B

LIFE: *I elect to convert my current Life Benefit:* __________

DEPENDENT LIFE: *I elect to convert my current dependent Life Benefit:* __________

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