CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

EMPLOYEE INFORMATION

Last Name	Name	Date of birth	Gender: ☐ F ☐ M	Contract Number
Address	City	State	Zip Code	Telephone
Applicant's Name (If not the employee):				
The Applicant is: ☐ Part Time Employee ☐ Regular Employee ☐ Surviving Spouse ☐ Ex-Spouse ☐ Dependent Child ☐ Other:				

Date that employee's coverage terminated: _____

Date that dependent's coverage terminated: _____

☐ I need time to decide
☐ I have been given the option of continuing my group health coverage, and i decline it.
☐ I wish to continue my group health coverage plan

	Name	Sex	Contract Number	Date of Birth
Employee				
Spouse				
Dependent				
Dependent				
Dependent				

I hereby certify that I been inform to pay the monthly required premium during the period established by the Health Plan Administrator. Not doing so, may result in the termination of my rights to continue coverage.

Applicant's Signature: _____ **Date:** _____
Company representative (authorized signature) _____ **Date:** _____

ELECTION AND FORM OF PAYMENT:

If you decide to continue your Group Health Coverage, you must notify the MCS during the first 60 days a following the date in which your coverage terminates, or (b), the date of this notification. It will be your responsibility to make your monthly payments $_____ (subject to change), payable to MCS Life Insurance, via automatic deduction, check, money order, debit card, Visa, Master Card or AMEX through our Call Center 1-888-758-1616.

The first payment along with this application must be delivered to MCS during the first (60) days of the qualifying event; otherwise; you may lose your rights to continue coverage. Subsequent payments should be sent to the Plan Administrator and should be received 30 days before the expiration date.

If you don't make a payment before the end of the grace period, your coverage will be suspended. If the election is made a month after the coverage with the company has ended, the law permits deferral of permits payments of the monthly payment for the period that precede your election nevertheless; this deferral payment period; (1) cannot exceed 45 days immediately following the date for the signature of your election; and (2) applies only to the payment period preceding the month in which the election was effective. If complete payment for this period is not made during the 45 days period, continuation of coverage will terminate.

INTERNAL USE OF HUMAN RESOURCE DEPARTMENT

I certify that the subscriber is eligible for benefit under the continuation of coverage established at COBRA Law and applicable amendments. Qualify event: _____ **Date of event:** _____ **( )** Eligible a HCTC Health Coverage Tax Credit
Coverage under COBRA from: _____ **to** _____ ☐ **18 Month** ☐ **36 Month**
Group Name: _____ **Group Number:** _____
Signature ant Title of the company Authorized Representative: _____ **Date:** _____