Notification Date_____

APPLICATION FOR CONTINUATION OF COVERAGE

Coverage applied for: (check one) _____ EMPLOYEE _____SPOUSE _____DEPENDENT

To be eligible for continuation, you must have been covered under the group health policy on the day before your coverage terminated.

If you choose to continue coverage, complete the information requested and return within 60 days from the date you receive this notice. Failure to elect within 60 days will forfeit your right to make an election at a later date. If you choose not to continue coverage, sign at bottom and return.

EMPLOYEE NAME _____ GROUP ID NUMBER _____

EMPLOYEE SOCIAL SECURITY/ID_____ GROUP NAME _____

BIRTH DATE _____ DATE OF QUALIFYING EVENT _____

My right to continue coverage is the result of: (check one)

_____1. Termination of employment, voluntary or involuntary (other than for "Gross Misconduct").
_____2. Reduction of hours.
_____3. Death of employee.
_____4. Divorce or legal separation.
_____5. Employee's Medicare eligibility.
_____6. Dependent child ceases to be eligible.

I wish to continue the following coverages for which I am eligible. Only list coverages that you were enrolled in on the date of your qualifying event; this does not apply to life or disability insurance.

If a dependent is electing continuation, please have him/her attach a copy of a completed group enrollment form. Lack of this information will delay the processing of this application.

COVERAGE	INDICATE SINGLE OR FAMILY
1. _____	1. _____
2. _____	2. _____

I elect **TO CONTINUE** group health coverage and I understand that this coverage will not remain in force if the premium is not paid.

_____ _____

Signature of Applicant Date Signed

VERY IMPORTANT NOTICE: You are not eligible for continuation of coverage if you are now covered or become covered under any other group health plan (i.e. your spouse's plan). COBRA continuation will be terminated if you are covered by another group health plan even if the other plan has a pre-existing condition limitation if that limitation does not apply to you because of the new federal portability rules of the Health Reform Act of 1996. Effective July 1, 1997, these new portability rules will allow you credit for the time covered under your prior employer plan.

*You must send your check or money order within 45 days of mailing this completed form. You must submit the same payment (unless you have been advised of a change) not later than the first of each following month. If you fail to make the monthly payment when due, your coverage will cease at the end of the period for which payment has been made subject to the grace period provisions of the plan and cannot be reinstated.

I elect ***NOT*** **TO CONTINUE** group health coverage.

_____ _____

Signature of Applicant Date Signed

N458-124

RETURN TO EMPLOYER