Date

Employee Name and Address

Dear _____;

This letter is to advise you that your insurance coverage under Company Name Employee Benefit Plan terminates as of _____ due to employment termination. You have the right, if you have been employed with Company Name for 3 months or more, to continue the coverage under this plan for yourself and your dependents covered under the plan beyond this date if you elect to do so in writing and send in all monthly premiums no later than the 25th of the each month.

If this continuation coverage is desired, you must sign below and return this form and the Election Form to Company Contact no later than 45 days after the coverage ends. If you do not send this form in by that date, you will lose your right to elect this continuation coverage.

The monthly premium for this continuation coverage is _____ for medical, _____ for dental and _____ for vision. This amount is subject to change based on Company Name company rates, which are based on the average age of the group electing coverage. A check in the amount of _____ is required with this completed form if you elect to take the coverage.

Your continuation coverage may be cut short for any of the following reasons.

Company Name no longer provides group health coverage to any of its employees.

The premium for your continuation coverage is not paid on time.

You become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition limitation or exclusion does not apply because of requirements restricting the application of pre-existing condition limitations and exclusions.

You become entitled to Medicare.

Maryland Continuation Coverage Election Form

I wish to continue coverage under the Company Name Employee Benefit Plan.

I understand that this election is subject to the plan. I have read and understand this continuation coverage.

I agree to send in the monthly premium amount of _____ no later than the 25th of each month

_____ _____

Name Date

_____ _____

Signature Date of signature

Billing Address:

Please make check payable to: Company Name