New York State
CONTINUATION OF COVERAGE ELECTION INFORMATION

Under the provisions of our Group Insurance Programs, your health insurance coverage will terminate on the Benefits End Date Indicated below. New York State Continuation Laws provide that you and/or your covered dependent(s) may apply to Continued Coverage under our Group Health Plan without being subject to a pre-existing condition exclusion or a significant gap in coverage. Also, you may be able to convert your group Life and LTD plans to individual plans. It is YOUR RESPONSIBILITY to contact the company benefits administrator or the insurance company for the proper paperwork. The paperwork must be submitted within 30 days of the date of termination, so it is in your best interest to contact the above mentioned immediately.

If you plan to elect Continuation of Coverage you must complete the information requested on the accompanying election attached to this form and return the completed form along with your payment within 30 days of this notice to:

Plan Administrator
Company Name
Company Address

In no event will we accept payment more than 45 days after receiving your election form.

You only need to return the election form if you are electing Continuation of Coverage.

- Pay all back payments for the covered period that follows your Benefits End Date and predates your Continuation of Coverage Election.
- Pay each subsequent monthly Continuation of Coverage payment prior to the first day of the month for which you are requesting coverage. Your checks should be payable to the company (__________ *Continuation*) and mailed to the above address. You will not receive bills from __________. Please include your social security number on your checks.

Coverage will end on the date the first of the following occurs:

* ______________ ceases to provide any group health plan to any employee; or

* You fail to make any required premium payment when due; or

* You become covered under any other group health plan, for which you are not subject to preexisting condition exclusion

* You become entitled to benefits for Medicare, after the date of election; or

* The expiration of 18 months of Continuation participation, or 29 months if disabled, (or become disabled during the first 60 days of Continuation coverage), or 36 months if coverage under Continuation is for a terminated dependent During the next 60 days you will have only one opportunity to elect Continuation Coverage. If you do not complete the Continuation of Coverage Election Form on the back of this notice and return it to the authorized person listed above within 60 days, you will lose your right to Continued Coverage.

Company Date
Representative Signed__________________
Terminated Employee's
Employee's Name Term Date________________
Benefits End Date
Date Coverage Ends (if you don't elect Continuation)___________
Continued Coverage End Date___________________

Continuation Premiums and Election

MONTHLY COSTS FOR
MedicalSingle $

EE\Spouse $

EE\Child $

Family $

Please note that the rates contain a 2% administration fee. Also, rates are subject to change at our yearly renewal.

PLEASE CIRCLE APPROPRIATE COST ABOVE AND SIGN BELOW

I accept continuation of benefits (Medical) as offered by __________for myself and\or my dependents.

Terminated Employee Signature___________________________________

Date______________________

Co. Representative ___________________________________

Date______________________

I decline Continuation benefits (Medical) as offered by ________________ for myself and\or my dependents.

Terminated Employee Signature_____________________________________

Date______________________

Co. Representative _____________________________________

Date ______________________