



COBRA Continuation Group Health Coverages

GE Financial
Employer Services Group

GE Group Life Assurance Company
100 Bright Meadow Boulevard
PO Box 1955
Enfield, CT 06083-1955

SECTION I: To be completed by employer.

EMPLOYEE'S NAME AND ADDRESS	ACCOUNT/POLICY NUMBER	OTHER ACCOUNT/POLICY NUMBER
	DATE INDIVIDUAL'S COVERAGE TERMINATED	NOTIFICATION DATE
	QUALIFYING EVENT (Reason - See Notice of Federal Continuation Rights for eligible Qualifying Events)	DATE OF EVENT
NAME OF FIRM AND ADDRESS TO WHOM MONTHLY CONTRIBUTION TO BE SENT*	COST OF CONTINUANCE BENEFIT*	
	<input type="checkbox"/> Dental only Single \$ _____ Family \$ _____ Dependent \$ _____ <input type="checkbox"/> Medical/Rx# only Single \$ _____ Family \$ _____ Dependent \$ _____	
	<input type="checkbox"/> Medical/Rx# and Dental Single \$ _____ Family \$ _____ Dependent \$ _____ <input type="checkbox"/> If plan includes an Rx plan, cards must be collected and Direct Reimbursement Forms used.	
SIGNATURE OF PLAN ADMINISTRATOR	DUE DATE OF PAYMENT	
	<input type="checkbox"/> Monthly _____ <input type="checkbox"/> Quarterly _____	

* NOTE: Payment for individuals electing the continuance must be sent to the Plan Administrator, payable to the firm. **DO NOT** remit payment independently to GE Group Life Assurance Company.

SECTION II: Employee/Dependent Instructions

I have read the Notice of Federal Continuations Rights, and as one of the qualifying events applies to me, I am exercising my continuation rights based on my qualifying event as noted above.

A. Employee Election

NAME (First, Last)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Receiving Social Security Disability Income	Are you eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you: <input type="checkbox"/> Applying for Social Security	Are you covered under any other Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICAL/RX <input type="checkbox"/> Deny <input type="checkbox"/> Elect	DENTAL <input type="checkbox"/> Deny <input type="checkbox"/> Elect	EMPLOYEE'S SIGNATURE
		DATE

B. Spouse Election

NAME (First, Last) AND ADDRESS (if different) (No., Street, City State, Zip)	SOCIAL SECURITY NO.	DATE OF BIRTH
Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Receiving Social Security Disability Income	Are you eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you: <input type="checkbox"/> Applying for Social Security	Are you covered under any other Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICAL/RX <input type="checkbox"/> Deny <input type="checkbox"/> Elect	DENTAL <input type="checkbox"/> Deny <input type="checkbox"/> Elect	SPOUSE'S SIGNATURE
		DATE

C. Dependent Child(ren) and/or Dependent Over Age Limit Election

NAME (First, Last)	NAME (First, Last)	
SOCIAL SECURITY NUMBER	SOCIAL SECURITY	
DATE OF BIRTH	DATE OF BIRTH	
MEDICAL/RX <input type="checkbox"/> Deny <input type="checkbox"/> Elect	MEDICAL/RX <input type="checkbox"/> Deny <input type="checkbox"/> Elect	
DENTAL <input type="checkbox"/> Deny <input type="checkbox"/> Elect	DENTAL <input type="checkbox"/> Deny <input type="checkbox"/> Elect	
NAME (First, Last)	PARENT'S SIGNATURE*	
SOCIAL SECURITY NUMBER	DEPENDENT'S SIGNATURE	
DATE OF BIRTH	DATE	
MEDICAL/RX <input type="checkbox"/> Deny <input type="checkbox"/> Elect	*The employee or spouse must sign for the dependent in the case of a minor	
DENTAL <input type="checkbox"/> Deny <input type="checkbox"/> Elect		

IMPORTANT INFORMATION

Conditions under which continuance is being offered:

1. If your medical plan has Basic Benefits, Basic Benefits must be maintained or we will apply the minimum dollar or day deductible used when you have not enrolled for Basic Benefits. This continuance **DOES NOT** apply to Life Insurance benefits. If you wish to continue your Life Insurance benefits you should apply for a conversion policy or, if you are disabled, you should apply for extended benefits. For more information, call Group Eligibility at 1-800-451-2513.
2. Details of the COBRA continuance benefit are contained in the Federal Continuation Section of the Group Certificate and should be reviewed carefully.
3. If you wish to elect continuation of coverage, you **must** return this form within 60 days of the notification date in Section I. If you do not make an election within this 60 day election period, you will lose your right to continuation coverage.
4. The first premium is due 45 days after the date you elect continuation coverage. Premiums due thereafter must be paid within 30 days after the due date unless a longer premium payment period is provided, otherwise coverage under the continuance terminates. Note: premiums must be sent to the Plan Administrator, payable to the firm. Premium must be paid before claims will be processed.
5. At the end of the full 18, 29 or 36 month period, whichever is applicable, you are allowed to enroll in a conversion plan, if a conversion option is included in the plan. If you wish to convert your coverage, you must advise the employer within 180 days before the end of the continuance period.

Please retain your copy of this form for future reference.