

(Date)

Name
Street Address
City, State, Zip Code

Dear (Name Above):

I have been notified that you are resigning from (School District) at the end of the (Year-Year) school year. Your group health, dental and vision insurance will remain in effect until (Date). As of (Date) you have the option to continue your coverage(s) beyond this date under what is called the COBRA Plan.

You have 60 days from the date of this letter to notify us of your election. Should you decline continuation coverage, then decide that you do wish to enroll, you may do so provided notice is given within this 60-day period.

If you elect this option, your coverage will be continued until the earliest of the following events (note - you may also have the right to a conversion policy following termination of COBRA coverage):

1. the expiration of 18 months following (Date);
2. you become covered under another group health care plan;
3. you become eligible for Medicare;
4. any invoice is not paid on or before the date it is due; or
5. our group health care plans are no longer in force.

I have attached an election form which includes the rates for coverage. Your first payment would be for the period beginning (Date) and must be received within 45 days of the date you sign this election form.

Subsequently, you will be billed as you have indicated on the election form (monthly, quarterly, semi-annually or annually). Each invoice will indicate the amount due, the due date and where to send your payment.

If you have any questions, please call me at (Area Code) (Phone Number).

Sincerely,

(Designated School Personnel)
(Title)

(SCHOOL DISTRICT)
 (Street Address)
 (City, State, Zip Code)
 (Area Code) (Phone Number)

ELECTION OF CONTINUED HEALTH, DENTAL AND/OR VISION INSURANCE

Name of Employee - _____ Employee Cert # - _____
 Eligibility Date - (Date) _____ Social Security # - _____

Authorized Signature _____ Date _____

Dependent(s) eligible for continuance:

COST OF INSURANCE	Health		Dental		Vision	
	Single	Full Family	Single	Full Family	Single	Full Family
Monthly	(\$Amt.)	n/a	(\$Amt.)	n/a	(\$Amt.)	n/a
Quarterly	(\$Amt.)	n/a	(\$Amt.)	n/a	(\$Amt.)	n/a
Semi-Annually	(\$Amt.)	n/a	(\$Amt.)	n/a	(\$Amt.)	n/a
Annually	(\$Amt.)	n/a	(\$Amt.)	n/a	(\$Amt.)	n/a

Premiums are subject to change for continuing insureds for the same reasons as active insureds.

Premium Due Date: **FIRST OF EACH MONTH (WITH A 30-DAY GRACE PERIOD)**

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 TO BE COMPLETED BY PERSON INSURED - PLEASE CHECK ONE OF THE FOLLOWING:

_____ I do not wish to continue my coverage according to these provisions. I understand my insurance coverage under this policy will cease as of the eligibility date listed.

_____ I do wish to continue my coverage under this policy. I desire a **MONTHLY, QUARTERLY, SEMIANNUAL OR ANNUAL (circle only one)** payment plan. I understand that timely payment of premium to the employer is required to keep my insurance in force.

Coverage(s) to be continued: _____ Health _____ Dental _____ Vision _____
 (circle only the coverage you wish to continue)

Name(s) of dependent(s) to be continued:
 1. _____ 3. _____
 2. _____ 4. _____

Are any of the individuals listed covered or eligible for coverage under Medicare?
(circle one) YES NO

Is there any other applied for or issued group coverage providing benefits for hospital, surgical, dental, vision or medical expenses or services for any of the above named individuals? **YES NO (If yes, please furnish details of coverage on back of this form)**

Your Address: _____

Signature: _____ Date: _____