Request for Continuation of Group Health Insurance

The Diocese of Charlotte, in an effort to provide continued health insurance for employees (or dependents of employees) who have been covered by the Diocesan Group Insurance Plan does voluntarily offer extended health insurance coverage. Coverage may be continued for up to eighteen (18) months at the member's own expense. The first premium and this completed form are due within sixty (60) days of the termination of your insurance. Future premiums are due monthly, and are payable to the Diocese of Charlotte **IN ADVANCE of the month of coverage**. For example, if you have terminated from employment of June 14, your coverage would be effective until June 30. You would be required to pay the first month's premium and submit this completed form to The Diocese of Charlotte NO LATER THAN July 10. The mailing address for payments and continuation forms is:

Diocese of Charlotte
ATTN: Human Resources Office
1123 South Church Street
Charlotte, NC 28203

All future monthly payments MUST BE RECEIVED AT THE DIOCESE OF CHARLOTTE NO LATER THAN THE 25TH OF THE MONTH PRIOR TO THE EFFECTIVE MONTH OF COVERAGE. In our continuing example, your August premium payment would have to be received at the Diocese NO LATER THAN July 25th. The September premium payment would be due NO LATER THAN August 25th, and so on.

FAILURE TO PAY THE PREMIUM ON TIME WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. COVERAGE CANNOT BE REINSTATED. Please return this form within sixty (60) days of termination of insurance. Failure to return this form in the time period allotted will be interpreted as a negative response to continued coverage, and coverage will be terminated.

Coverage Election

I have been covered under the Diocesan Group Insurance Program for at least three months, but my coverage is terminating due to:

- ☐ Termination of employment – Resignation or Discharge
- ☐ Reduction of hours (to less than 30 hours per week)
- ☐ Disability (Natural Causes/Workers' Compensation)
- ☐ Dependent loss of eligibility
- ☐ Death of Insured

I wish ☐ I do not wish ☐ to continue my Group Coverage per the Diocesan Policy on Continuation of Group Health Insurance, which I have read above and understand.

Date of Last Employment/Regular Full-time Work (if applicable): _____

Monthly Premium: _____

Employee Signature: _____ Date: _____

Print Name: _____ SS #: _____