



NOTICE OF HEALTH COVERAGE CONTINUATION OR CONVERSION

SECTION I: (To be completed by Employer)

Account No.: _____ Employer/Company Name: _____

My Employee, _____, terminated employment on _____

because of (check reason):

- 1. voluntary termination
- 2. involuntary termination
- 3. layoff
- 4. retirement
- 5. other (please specify): _____

 Employer's/Company's Authorized Representative Signature Title Date

Employer: If employee elects to continue coverage, please insert the amount of premium to be paid in the space indicated below in Section II.

SECTION II: (Employee's Notice of Right to Continuation of Coverage)

If your coverage under the Central Reserve Life (CRL) group plan terminates, this form will serve as notification of your right to continue the medical expense portion of the insurance for a period of up to six (6) months,* provided that:

1. you have been continuously insured under the CRL plan and any group plan it replaced during the entire three (3) month period immediately preceding the termination of your employment;
2. you are entitled to Unemployment Compensation Benefits (not applicable in Virginia and West Virginia); and
3. you are not eligible for any similar group coverage or for Medicare.

*Eighteen (18) months in the event of involuntary layoff in West Virginia.

If you elect to continue coverage, it will terminate at the earliest of the following:

1. the date you become covered by, or eligible for:
 - a. Medicare; or
 - b. coverage by any other insured or uninsured plan that provides Hospital, Surgical, or Medical coverage for individuals in a group under which you were not covered immediately prior to termination of employment;
2. the end of the six (6) month continuation period;
3. the end of the period for which premium is paid; or
4. the date the Policy terminates or the date your employer's membership in the group plan terminates.

To continue your health insurance coverage with CRL, this completed form and the first month's premium must be received by CRL's Home Office within sixty (60) days of the date insurance would otherwise end, regardless of the date your employer gives you notice of continuation rights.

The monthly premium for continuation of coverage is \$ _____. **(Employer: please insert amount of premium.)**

Premium Instructions: Following receipt of this form, CRL will send the employee/dependent instructions for submitting the required premium. The initial premium payment must be received at CRL's Home Office by the sixtieth (60th) day of the date the insurance would otherwise end. The initial payment must include all premiums due from the date of the qualifying event to the current date. All future premiums must be submitted through the employer. Premiums are subject to change as the employer's rate changes.

(See other side for Section III.)

SECTION III: (To be completed by Employee)

After having read the above notice carefully,

- YES, I elect to continue my group health coverage for:**
 myself only or
 myself and my dependents.

I certify that:

- I am
 I am not
- currently entitled to unemployment compensation benefits.

- I am
 I am not
- currently eligible for any other group health insurance plan or Medicare.

- NO, I do not elect to continue my group health coverage.**

Signature of Employee

Date

Street Address

(_____) _____
Area Code Telephone Number

City, State, Zip Code

NOTICE: For Ohio insureds only: We are required by Ohio law to inform you of the following: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

NOTICE: For Pennsylvania insureds only: We are required by Pennsylvania law to inform you of the following: "Any person who knowingly and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

Note: If you choose to continue your health insurance coverage, as offered above, you may also have the option, either now, during, or at the end of the six (6) month continuation period, to convert to an individual health insurance policy. Please contact a CRL Customer Service Representative at 1-877-575-4201 for information on eligibility, the type of coverage available, and the rates.

For Office Use Only

CRDA: _____