

EMI Health COBRA Continuation Application

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Plans underwritten or provided by Educators Mutual Insurance Association of Utah • Educators Health Plans Life, Accident, and Health, Inc.

Effective July 1, 1986, Public Law 99-272 (COBRA) made it mandatory for employers of 20 or more full-time persons to provide continuation of group insurance coverage upon the occurrence of a "qualifying event" of an employee (see below). To comply with the COBRA law, we ask that terminated employees or their dependents indicate if they wish to continue insurance coverage by completing and signing this form.

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Phone Number NOTIFICATION OF RIGHTS UNDER CONTINUATION OF HEALTH INSURANCE COVERAGE ACT OF 1986: Ihereby certify that I have been notified of my rights under the Continuation of Health Insurance Coverage Act of 1986. Lunderstand that under under the plan with respect to whom a qualifying event has not occurred. I further understand that I am required to pay the premium, which may not exceed 102 percent of applicable premium, for any period of continuation coverage. The "Qualifying Event" is Benefits can be continued up to Benefits with the plan with respect to whom a qualifying event has not occurred. I further understand that I am required to pay the premium, which way not exceed 102 percent of applicable premium, for any period of continuation coverage. The "Qualifying Event" is Benefits can be continued up to Benefits can be con	Applicant's Last Name First Middle Sex Bi				rthDate	thDate Social Security Number					
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Name and social security number of previous EMI Health contract holder: Name: Coverage desired: [Please check only employer-sponsored benefits.] OTHER INSURANCE INFORMATION [THIS SECTION MUST BE COMPLETED] Do you, your spouse, or dependents have other medical or dental coverage [including Medicare]? Yes No If so, what type of coverage? Medicare Part A Medicare Part B Other Medicare] If so, what you of coverage classification? Single Couple Family Name of Insured SSN: Name of Other Insurance Company. Please provide any of the following information you may have: Group and/or Policy Number: Effective Date: Insurance Company Phone Number: RELATIONSHIP RELATIONTO LIST ALL FAMILY MEMBERS TO BE COVERED SEX MOD DAY YEAR NUMBER AS EMPLOYEE Sopone 3.	☐ Termination of employment (for other than gross misconduct).18 months☐ Work hours reduced below eligibility requirements.18 months☐ Dependent coverage terminated due to death of employee.36 months☐ Divorce or legal separation from employee.36 months☐ Spouse or dependent of Medicare-entitled individual.36 months☐ A dependent child ceases to be a dependent under the generally applicable requirements of the plan.36 months									months months months months months months	
Do you, your spouse, or dependents have other medical or dental coverage [including Medicare?]	Name of previous employer (district or institution):										
TO EMPLOYEE EMPLOYEE TO BE COVERED SLA MO DAY YEAR NUMBER AS EMPLOYEE CODE KEY: 1 1. Employee	Do you, your s If so, what typ If so, what is t Nan Insu Nan Please provid Grot	spouse, or de le of coverage the coverage ne of Insured lred's SSN: _ ne of Other In e any of the f up and/or Po ctive Date: _	ependents have other medicale?	l or dental cove	erage (inc icare Par ouple	t B	Medic Family	care)? Other y	Yes Medical	Dental	
S. Spouse N: Natural Child SC: Step Child O: Other Solid Content	TO EMPLOYEE CODE KEY:	EMPLOYEE	TO BE COVERE 1. Employee		SEX	MO	THDAT DAY	YEAR	SO		AS EMPLOYEE
I recognize that this offer is independent of any other offer to continue insurance as may be required by the law of any state that applies to this coverage. I certify that I am not presently, nor will I, to the best of my knowledge, be covered under another group health plan within 31 days of this date. I understand that this coverage will terminate on the date that I become covered by other group insurance coverage due to employment, remarriage, or at the expiration of my maximum continuation period. I understand that failure to pay the monthly premium will result in cancellation of the insurance. I further understand that my failure to return this form in a timely manner constitutes waiver of my rights of continuation under COBRA. I authorize EMI Health to share medical information concerning me or my family with any health care provider providing health benefits within the scope of the group contract. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.	S: Spouse N: Natural Child SC: Step Child		3. 4. 5.								
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