EMI HEALTH™

EMI HEALTH TEXAS 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.

Applicant's Last Name	First	Middle	Sex	BirthDate	Social Security Number	
Current Address			City	State	Zip	PO Box
Phone Number						

NOTIFICATION OF RIGHTS UNDER CONTINUATION OF HEALTH INSURANCE COVERAGE ACT OF 1986:

I hereby certify that I have been notified of my rights under the Continuation of Health Insurance Coverage Act of 1986. I understand that under the Act I am entitled to be provided with the type of coverage under the plan identical to the coverage provided to similarly situated beneficiaries 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**
☐ Termination of employment (for other than gross misconduct).	24 months
☐ Work hours reduced below eligibility requirements.	24 months
☐ Dependent coverage terminated due to death of employee.	42 months
☐ Divorce or legal separation from employee.	42 months
☐ Spouse or dependent of Medicare-entitled individual.	42 months
☐ A dependent child ceases to be a dependent under the generally applicable requirements of the plan.	42 months
☐ Bankruptcy of the employer.	42 months

Date of qualifying event causing termination of group health care plan: _____

Name of previous employer (district or institution): _____

Name and social security number of previous EMI Health contract holder: _____

Name: _____ SSN: _____

Coverage desired: (Please check only employer-sponsored benefits.) ☐ Medical ☐ Dental ☐ Vision

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 Medical ☐ Dental

If so, what is the coverage classification? ☐ Single ☐ Couple ☐ Family

Name of Insured _____

Insured's 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 TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED	SEX	BIRTHDATE MO	BIRTHDATE DAY	BIRTHDATE YEAR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE
CODE KEY: I: Self S: Spouse N: Natural Child SC: Step Child O: Other	I	1. Employee						YES
		2.						
		3.						
		4.						
		5.						
		6.						

ELECTION TO PARTICIPATE

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.

_____ _____

Applicant's Signature Date