Toledo Electrical Welfare Fund
Request to Continue Group Health Care Plan Coverage

Return this form to: **Toledo Electrical Welfare Fund, P.O. Box 60408, Rossford, OH 43460-0408**

Instructions: (1) Fill in the name, Social Security number and birth date of the covered employee
(2) Fill in the name, Social Security number and birth date of all other covered individuals
(3) Check, for each individual, the box(es) to indicate whether the individual wishes to continue coverage

	Name	Social Security No.	Birth Date	Full Medical* Medical, Rx Only	Full Medical* Medical, Rx, Dental & Vision	Basic Medical Only*
Employee	_____	_____	_____	❑	❑	❑
Spouse	_____	_____	_____	❑	❑	❑
Child	_____	_____	_____	❑	❑	❑
Child	_____	_____	_____	❑	❑	❑

NOTE: Family coverage is only available to those families who were covered as families prior to the qualifying event.

*Basic or Full Medical availability depends on coverage prior to the qualifying event.

Address to which correspondence should be sent: **(Please keep us informed of any change of address)**

_____	_____	_____	_____
Street	City	State	Zip Code

I understand that I can make an election 60 days from the later of the date of termination of coverage or the date of the notice. I further understand that I have 45 days from date of election to remit my first payment which must include premiums for the entire period retroactive to date of the qualifying event. Subsequent payments are due on the first of each month. Failure to remit this payment within 30 days of the monthly due date will result in cancellation of the extension of coverage. Claims become payable for each period of coverage only after a premium payment for the coverage period has been made.

I understand that my coverage will stop if I fail to pay the required premium, if I become covered by another group health care plan that does not limit coverage for any pre-existing condition I may have, if I become entitled for Medicare, or if the Toledo Electrical Welfare Fund cancels all group health coverage for all its employees.

I further understand that the continuation period starts on the "date of qualifying event" listed below and lasts for the "maximum number of months" listed below.

Qualifying Event: _____ Date of Original Qualifying Event: _____

Maximum number of continued coverage months: _____

Signature: _____ Date: _____

(For Organization Use Only)

Original Covered Employee: _____ Social Security No.: _____
Notice Date: _____ Date Returned: _____
Copy Sent to: _____ On: _____