



GA 90-DAY CONTINUATION ELECTION FORM

Group Name: _____ Group #: _____

Employee: _____
(Last Name) (First Name) (Middle)

DOB: ____/____/____ SSN: ____-____-____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (Home): _____ (Work): _____

Dependent Name(s)

SSN: ____-____-____

SSN: ____-____-____

SSN: ____-____-____

Have you been continuously covered under the group contract/plan for at least six (6) months immediately prior to termination? Yes No (If "no", you are not eligible for GA 90-day continuation.)

Last day employed: _____

I elect waive continuation of the following coverage:

Employee \$ _____/month Employee+Spouse \$ _____/month

Employee+Child \$ _____/month Family \$ _____/month

I elect to continue the above selected coverage for:

1 month 2 months 3 months

If electing to continue, please answer the following question:

Do you and/or dependents on your plan have other health coverage? (including Medicare Part B)

Yes No

If "yes", please list the family member(s) and the name, phone #, and policy # of the insurance company.

Premiums for any plans you elect are due by _____.

If we do not receive full payment within 30 days of the due date, your coverage will be canceled.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____