

Continuation of Coverage

You may fax this form to (574) 537-3630 (for ShareNet Employer Plan) or (574) 537-6642 (for GroupCare or Congregational Employee Plan).

Group name _____

Employee's name _____

Agreement number _____

- Plan GroupCare
 ShareNet Employer Plan
 Congregational Employee Plan

The following participants have elected to continue on our group plan (check all that apply):

- Employee
 Spouse
 Dependent(s) _____
Name

The following coverages need to be continued (check all that apply):

- Medical
 Dental (if offered and administered by MMA)

Reason for continuation:

- Loss of employer coverage due to termination or reduction in hours of employment
 Divorce or separation
 Death of employee
 Medicare entitlement
 Dependent no longer meets eligibility requirements

Date to begin continuation of coverage _____

Scheduled date to end continuation of coverage

(unless other qualifying events occur – please notify us with new date) _____

Special instructions _____

Group representative's signature

Date



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