STATE OF ARKANSAS CONTINUATION OF COVERAGE ELECTION FORM

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

SUBMIT TO: Small Group Underwriting, Suite 800
P.O. Box 2181
Little Rock, AR 72203-2181
FAX: 501-378-2926
EMAIL: smallgroupunderwriting@arkbluecross.com

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Name: _____ ID#: _____

Dependent Name(s): _____ Group Name: _____

_____ Group#: _____

The State of Arkansas Continuation Law (A.C.A. §23-86-114) allows a Covered Person to extend their Group Health Insurance Policy coverage for up to 120 days. In order to be eligible for this option, the Covered Person must have been continuously covered under the Group Health Insurance Policy for at least three consecutive months prior to employment termination or change in dependency status and must make the election by notifying the Company (Arkansas Blue Cross and Blue Shield or Health Advantage) no later than 10 days after employment termination or change in dependency status. The Group Health Insurance Policy premium must be paid in full by the Covered Person to the Group (Policyholder) by the date specified below. Failure to pay this premium will result in cancellation of coverage for the employee and/or any dependents on such Group Policy.

❑ I,_____, wish to continue my group health insurance coverage under the State of Arkansas Continuation Law beginning _____/_____/_____. The premium amount of $_____ must be paid to my employer by _____/_____/_____ or my coverage will be terminated. This continuation of coverage shall terminate on the earliest of:

- One hundred and twenty days after the date the election is made;
- The date the Covered Person fails to make any premium payments to the Policyholder or the date the Policyholder fails to pay the premium to the Company;
- The date on which the Covered Person becomes eligible for Medicare;
- The date on which the Covered Person is covered for similar benefits under another group or individual policy;
- The date on which the Covered Person is eligible for similar benefits under another group plan whether insured or uninsured;
- The date on which similar benefits are provided for, or available to the Covered Person under any state or federal law;
- The date on which the Group Policy terminates.

❑ I have read the statements above and do not wish to continue group health insurance coverage under the State of Arkansas Continuation Law (A.C.A. §23-86-114), for myself and/or any eligible dependents.

_____ _____
Signature of Employee Date of Signature

_____ _____
Signature of Group Administrator Date of Signature