



EMPLOYEE CERTIFICATE NO. _____

Date notification was given for continuance _____

NOTE: Medical and/or Dental insurance may be continued subject to COBRA guidelines and STATE continuance laws.

TO BE COMPLETED BY EMPLOYER

Employer name _____

Number of full-time employees _____ Number of part-time employees _____

Did your firm consistently employ 20 or more, full and part-time, employees for 50% of its business days during the previous calendar year? Yes No

Qualifying event has occurred for Employee Dependent

Date of qualifying event _____ Reason _____

Authorized employer signature _____ Date _____

TO BE COMPLETED BY APPLICANT

Insurance to be continued Major Medical (if applicable) Dental (if applicable)

Persons to be continued _____

Name
EMPLOYEE
SPOUSE
CHILD
CHILD
CHILD
CHILD

Are any of the individuals listed above:

1. Covered by Medicare or Medicaid? Yes No If "Yes," effective date _____

2. Covered by comprehensive coverage under any group or individual health insurance plan? Yes No

If "Yes," provide the following information.

A. Name of carrier _____ Effective date _____

B. Will your coverage be subject to any pre-existing conditions or waiting period? Yes No

C. If "Yes," provide length of waiting period and/or pre-existing condition _____

Mail this form to: Assurant Health – Premium Services, P.O. Box 9398, Minneapolis, MN 55440-9398

or fax this form to Premium Services 763-577-4594.

Applicant signature _____ Date _____