



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 \_\_\_\_\_