OFFICE OF INSURANCE REGULATION
Life & Health Product Review

ELECTION AND PREMIUM NOTICE FORM

[Carrier's/Designee Name]
[Carrier's/Designee's Address]
[Carrier's/Designee's Telephone Number]

To Elect Continuation Of Coverage, the qualified beneficiary must complete the information below and return this form with a check in the amount of the applicable premium for the coverage selected to the address above within 30 days of receipt of this form. If you do not elect to continue coverage, please sign and indicate on signature line below and return.*

Personal information re: Applicant Electing Continuation of Coverage

Name: _____ **Date of Birth:** _____
Last, First Middle

Sex: ☐ Male ☐ Female **Social Security Number:** _____ – –

Applicant's Current Address: _____
(Number, Street, Apartment Number)

_____
(City, State Zip Code)

Daytime Phone Number: ( )– –

I elect to continue group health coverage for:	**Premium Amount**
☐ **Employee Only**	**$**
☐ **Employee/Spouse***	**$**
☐ **Spouse Only**	**$**
☐ **Employee/Spouse/Child(ren)**	**$**
☐ **Employee/Child(ren) Only**	**$**
☐ **Spouse/Dependents**	**$**
☐ **Dependent Only**	**$**
Total Premium	**$**

List dependent(s) whose coverage the applicant wants to continue. Dependents who are eligible to make independent election under Florida Continuation of Coverage and wish to do so, must complete a separate Election and Premium Notice Form.

Dependent's Information **(please complete the information below for all dependents)**

Name: Last, First Middle	**Sex**	**Social Security #**	**DOB**	**Relationship**
		– –		
Name: Last, First Middle	**Sex**	**Social Security #**	**DOB**	**Relationship**
		– –		
Name: Last, First Middle	**Sex**	**Social Security #**	**DOB**	**Relationship**
		– –		
Name: Last, First Middle	**Sex**	**Social Security #**	**DOB**	**Relationship**
		– –		
Name: Last, First Middle	**Sex**	**Social Security #**	**DOB**	**Relationship**
		– –		
Name: Last, First Middle	**Sex**	**Social Security #**	**DOB**	**Relationship**
		– –		

ADDITIONAL REQUIRED INFORMATION:

Employer's Name: _____

Address: _____

_____

Employer's Group Number: _____

Employee's Contract/ID/Plan Number: _____

***Signature of Employee/Qualified Beneficiary:** _____

Today's Date _____ ☐ **I DO NOT Elect Coverage**

THIS FORM WITH THE APPLICABLE PREMIUM MUST BE COMPLETED, SIGNED AND SENT TO [CARRIER/DESIGNEE] WITHIN 30 DAYS OF RECEIPT OF THE NOTICE. IF THE EMPLOYEE OR A QUALIFIED BENEFICIARY DOES NOT SEND THIS ELECTION FORM WITH THE APPLICABLE PREMIUM WITHIN THE 30-DAY TIME PERIOD ALLOWED BY, THE QUALIFIED BENEFICIARY WILL LOSE THE RIGHT TO CONTINUATION OF COVERAGE.

The [carrier/designee] will bill the qualified beneficiary for applicable premiums once each month with a due date of the first of the month. The qualified beneficiary will have a 30 day grace period in which to pay each monthly premium. If the applicable premium is not paid before or within the 30 day grace period, continuation of coverage will be cancelled as of the last paid to date.