

STATEMENT OF CHANGE OF ACTIVE EMPLOYMENT

PART I – TO BE COMPLETED BY EMPLOYER

Employer Name:	Location ID No.:
Name of Employee: <i>Last</i> <i>First</i> <i>Middle</i>	Social Security No.:
<p>(please check one):</p> <input type="checkbox"/> Disability <input type="checkbox"/> Leave of Absence–FMLA <input type="checkbox"/> Termination/Resignation <input type="checkbox"/> Leave of Absence–Personal <input type="checkbox"/> Reduction of Work Hours <input type="checkbox"/> Leave of Absence–Medical # of hours _____ <input type="checkbox"/> Death: Date _____ <input type="checkbox"/> Cancel Medical Extension: Effective Date _____ <input type="checkbox"/> Retirement (Please complete questionnaire below) <input type="checkbox"/> Teacher/Contract Ends: Date _____ <input type="checkbox"/> Other (attach explanation to this form)	Date of Birth:
	Actual Last Day Worked:
Dependents: (Information needed to meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA))	
<i>Last</i> <i>First</i> <i>Middle</i> <i>Social Security No.</i>	
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<i>Last</i> <i>First</i> <i>Middle</i> <i>Social Security No.</i>	
Signature:	Title: Date:

PLEASE READ CAREFULLY AND COMPLETE SECTION BELOW IF CONTINUING COVERAGE.

An employee whose group coverage terminates due to a reduction of work hours or termination of employment (other than for gross misconduct) can continue benefits for himself or herself and his/her covered dependents for up to 18 months. Coverage cannot be continued if the person is covered under another group plan, or if the person is eligible for Medicare.

■ When coverage ends because an individual becomes covered under another group plan, and that plan contains a preexisting condition exclusion or limitation which would affect the individual's benefits, coverage could be continued during the preexisting period. The maximum continuation period in any case other than disability would be 18 months, starting the first month following the last day of work. ■ A disabled person who receives a social security award could extend group benefits an additional 11 months or until Medicare becomes effective, or other coverage is in effect, whichever is earlier. ■ Coverage cannot be continued if the proper contributions are not made or if the group plan terminates.

■ An individual must have been enrolled for group coverage for at least three months to be eligible to extend coverage (except approved Leave of Absences).

■ Please refer to Your Employee Benefits Booklet for eligible retiree requirements.

Please check one:

I do not elect to continue my benefits under the group plan.

I elect to continue my benefits under the group plan. Please continue coverage for:

Employee Employee and Eligible Dependents

NOTE: You must advise the employer, *in writing*, in the event you are no longer eligible for continuation or you no longer wish to continue your optional benefits. I certify that I am not covered under any other group insurance plan at this time, nor eligible for Medicare (please disregard if continuing as an eligible retiree or on an approved Leave of Absence).

Name of Person Making Election (please print):	Signature of Person Making Election:	Date:
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QUESTIONNAIRE TO BE COMPLETED BY THE EMPLOYER IF RETIREMENT IS MARKED ABOVE.

The following questions will assist in our determination of who will be the primary payor on the retiree; CBEBT or Medicare.

1. Will the retiree be paid for any accrued sick time? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, thru what date will the retiree be paid? _____
2. Will the retiree be paid for any accrued vacation time? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, thru what date will the retiree be paid? _____
3. What is the date of retirement which you are reporting to Medicare?

Signature of Benefits Administrator: