

MARYLAND CONTINUATION ELECTION FORM

I wish to continue coverage under the <Name of Company> Employee Benefit Plan. I understand that this election is subject to the Plan. I have read and understand the MD Continuation Coverage Notice and the letter that accompanied this election form and both MD Continuation rights and limitations on those rights.

YES NO

IF YES, PLEASE ATTACH A NEW APPLICATION

Effective date of continuation coverage: _____

First payment is enclosed: YES NO

(If first payment is not enclosed, you will not be able to access health care coverage until payment is received.)

Qualifying Event:

Termination of
Employment

Death

Divorce

Type of Insurance Selected:

Health

Dental

Vision

(May not add lines of Insurance until Open Enrollment.)

Type of Coverage Selected:

Individual

Husband/Wife

Parent/Child

Family

(Dependents may not be added until Open Enrollment unless a change in family status occurs.)

Signature

Date

Print Name

Social Security Number

Signature of Witness

For Employer to complete:

Continuation coverage end date: _____

Bill to Company:

Bill to Qualified Beneficiary:

Billing address

City

State

Zip