

**Kansas  
Group Benefit Continuation Request**

Name \_\_\_\_\_ Certificate Number \_\_\_\_\_

Address \_\_\_\_\_ Group Number \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_ Effective Date \_\_\_\_\_

My health coverage has terminated, but I understand that under certain conditions, my eligible dependents and I may continue the group coverage at the group rate for a period not to exceed six months.

I also understand:

- A. I must return this form and pay the required contribution amount within 31 days of the date coverage would otherwise terminate.
- B. Continuation of group coverage will terminate upon the first of the following:
  - (1) Six months after coverage would have otherwise terminated;
  - (2) My failure to make timely payment of the required contribution; or,
  - (3) I (or my dependents) become eligible to be covered under Medicare or any other group plan.
  - (4) The discontinued group contract is replaced by similar group coverage within 31 days.

Check one:

- I would like to continue the coverage for myself only.
- I would like to continue the coverage for myself and my eligible dependents.
- I do not wish to continue coverage.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**BlueCross BlueShield  
of Kansas City**

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