

**Missouri
Group Benefit Continuation Request**

Name _____ Certificate Number _____

Address _____ Group Number _____

City/State/Zip _____ Effective Date _____

- My group health coverage has terminated because of termination of employment.
- I am a dependent whose group health coverage has terminated because of divorce or death of the employee.

Name of employee _____

I understand that under certain conditions, my eligible dependents and/or I may continue the group health coverage at the group rate for a period not to exceed nine months.

I also understand:

- A. I must return this form and pay the required contribution amount within 31 days of the date coverage would have otherwise terminated;
- B. Continuation of group coverage will terminate upon the first of the following:
- (1) Nine months after coverage would have otherwise terminated;
 - (2) My failure to make timely payment of the required contribution;
 - (3) The date I (or my dependents) become eligible to be covered under Medicare or any other group plan, whether or not covered; or,
 - (4) The date the group contract terminates.

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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