AIG

AIG Benefit Solutions
Underwritten by
American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company In the City of New York
New York, New York
National Union Fire Insurance Company of Pittsburgh, PA
New York, New York
*This company does not solicit business in New York

Cal-Cobra Information Request/ Continuation Election Form

Administrative Office: P. O. Box 15250, Amarillo, TX 79105-5250
Phone: 1-877-672-1648 Fax: 713-521-6047

If you or an insured dependent have had a qualifying event, continuation of coverage may be available. The person(s) whose coverage is to continue is responsible for paying the required premium. To determine the required premium, you may ask your employer. If you cannot obtain this information from your employer, please check the box for Section I and indicate below which premium information you require. Please return this form to the address indicated at the bottom of this form. If you know the required premiums and which insurance to continue, please check the box for **Section II**, and complete all applicable information and return this form to the address indicated at the bottom of this form.

EMPLOYER'S NAME:_____ **GROUP POLICY NUMBER:**_____

YOUR ADDRESS:_____

SECTION I
I request notification that explains Cal-COBRA rights of continuation and the required premium rates for continuation of the following coverage(s), (check any or all items as applicable to the coverage that is or was in force):

Employee Dental Rate _____ Employee Vision Care Rate _____
Spouse Dental Rate _____ Spouse Vision Care Rate _____
Dependent Child Rate _____ Dependent Vision Care Rate _____

SECTION II
I request continuation of coverage as indicated below:

	Name	DOB	Social Security #
Employee			
Spouse			
Dependent Child			

Qualifying Event	Date of the Event
End of Employment/Ceasing to be Eligible	
Death of Employee	
Divorce	
Child Ceases to be Eligible	

1. ELECTION
I elect continuation of employee health insurance; I elect continuation of spouse health insurance; I elect continuation of child(ren) health insurance.
Note: If you elect to continue insurance, you must complete the INSURANCE TO BE CONTINUED section below.

2. INSURANCE TO BE CONTINUED:
You may elect any combination shown below, but only coverage that was previously in force may be continued.

Employee:	☐ Dental Benefits	☐ Vision Care Benefits
Spouse:	☐ Dental Benefits	☐ Vision Care Benefits
Dependent Child(ren):	☐ Dental Benefits	☐ Vision Care Benefits

3. ACKNOWLEDGEMENT/SIGNATURE
- I acknowledge that I have received and read the attached notice that explains the Cal-COBRA rights of continuation.
- I understand that if I elect to continue insurance, the payment of premium for it is my sole responsibility. I further understand that if premium is not received within 31 days of my premium due date, my insurance will automatically end as of the last day of the period for which premium was paid.

EMPLOYEE SIGNATURE *DATE SIGNED*

*CHILD SIGNATURE (FOR CHILD AGE 18 OR OVER)** *DATE SIGNED*
**EMPLOYEE SHOULD SIGN FOR A MINOR CHILD*

SPOUSE SIGNATURE *DATE SIGNED*