CenturyLink™

EMBARQ RETIREE
SUSPENSION OF COVERAGE FORM

Retiree Name: _____
(Please print)

Retiree SSN: _____

Effective Date: _____
(This date must be the first day of a month)

Forms received prior to the 15th of the month, will be processed the 1st of the following month. Forms received after the 15th of the month, will be processed the 1st of the second following month.

I hereby elect to suspend coverage for myself under the:

_____ Embarq Retiree Medical Plan (includes Prescription Drug Program)
_____ Embarq Retiree Dental Plan

I currently am covered by another employer plan as an active employee, retiree, or dependent of my spouse/qualified domestic partner.

Listed below is the information for the other medical/dental plan that I currently am covered under:

Medical Plan Name: _____
Sponsoring Employer: _____
Group Plan Number: _____

Dental Plan Name: _____
Sponsoring Employer: _____
Group Plan Number: _____

I understand that once my coverage under the other group plan ends, I must notify the EMBARQ within 60 days to begin participating in the Embarq Retiree Medical Plan (includes the Prescription Drug Program) if not Medicare eligible and/or the Embarq Retiree Dental Plan. If I do not, neither I, nor my dependents, can be re-enrolled in these Plans in the future. PLEASE MAKE A COPY FOR YOURSELF BEFORE SENDING THE SIGNED DOCUMENT TO THE EMPLOYEE RESOURCE CENTER.

Retiree Signature: _____ **Date:** _____

Retiree SSN: _____