SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN

500 East Capitol Ave. - Pierre, SD 57501-5070

APPLICATION TO CONTINUE BENEFITS - (COBRA)

Name: _____ Social Security #: _____
Last First Middle Alternative ID# _____

Mailing Address: _____
Street City State Zip Code

Daytime Phone #: _____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

All questions must be answered in full. Please check the appropriate answer and provide the necessary information. **PAYMENT FOR CONTINUATION OF COVERAGE MUST BE PAID BY DIRECT PAYMENT PLAN.** Please refer to the Direct Payment Plan instruction sheet. ***Failure to complete both forms and return in a timely manner may result in loss of coverage.***

1) I am: ☐ a former employee ☐ a participating family member
(If electing continuation coverage, please complete the Direct Payment Plan form and attach a voided check.)

If you are a participating family member, please list current or former employee information:

Name: _____ Emp. Soc. Sec. No. _____-_____-_____

2) ☐ **I DO** elect continuation coverage.
☐ **I DO NOT** elect continuation coverage. (Please complete the information above, sign and return this form.)

3) Participant and/or dependent information for each person who will be continuing coverage:

Name	**Birth Date**	**Soc. Sec. No.**	**Which Plan(s)?**

4) I request continuation coverage for the following plans: **(Check all that apply.)**

- ☐ State Group Health Plan
  - ☐ $300 Deductible/Copay Plan
  - ☐ $1000 Deductible Plan
  - ☐ $2000 Deductible Plan
- ☐ State Group Term Life Benefit Plan (See reverse for details)
- ☐ Medical Reimbursement Account component of Flex Plan
- ☐ Delta Dental Plan component of Flex Plan
  - ☐ Basic Plan
  - ☐ Enhanced Plan
- ☐ Vision Plan component of Flex Plan

5) Non-tobacco User or Tobacco User?

- ☐ I am **not** a tobacco user
- ☐ I am a tobacco user
- ☐ My covered spouse is **not** a tobacco user
- ☐ My covered spouse is a tobacco user

6) Which qualifying event(s) make you eligible for continuation coverage?

- ☐ Employee Termination
- ☐ Employee Death
- ☐ Reduction of Employee's Hours
- ☐ Child is Ineligible to be Covered as a Dependent
- ☐ Divorce or Legal Separation
- ☐ Receiving Coverage Under Medicare
- ☐ Disabled Employee
- ☐ Retired Employee

FOR THIS ELECTION TO BE VALID, YOU MUST FULLY COMPLETE, SIGN, AND DATE THE BACK OF THIS FORM.

(OVER)

GROUP TERM LIFE BENEFIT ELECTION

State employees who have terminated or experienced a reduction of hours which would make them ineligible to participate in the Group Term Life Plan may continue their coverage in addition to or exclusive of any plan listed on the front of this form. ***Dependent life coverage cannot be continued.***

GROUP TERM LIFE COVERAGE MAY ONLY BE CONTINUED FOR AN 18 MONTH PERIOD OR UNTIL THE END OF THE MONTH IN WHICH THE PARTICIPANT REACHES AGE 70, WHICHEVER OCCURS FIRST.

Coverage may be voluntarily terminated by the participant through written notification to the SD Bureau of Personnel, the Plan Administrator, or by failure to make timely payments.

The **maximum** amount of coverage that may be continued is the amount in-force at the time of the qualifying event. The **minimum** amount that may be continued is the Basic $25,000. You may choose an amount in between the minimum and maximum coverage in increments of $1,000.

Please check the appropriate level of life coverage desired. You must check ONE of the following:

- ☐ I **DO NOT** elect to continue my group term life coverage
- ☐ I **DO** elect to continue the total amount in-force
- ☐ I **DO** elect to continue the Basic amount of $25,000
- ☐ **Other**, specify $_____,000
- ☐ **N/A**, Spouse/Dependent Coverage

Beneficiary(ies) should be designated if you elect to continue Group Term Life Coverage.
For your protection, scratch-outs, and whiteouts are not accepted.

DESIGNATION OF PRIMARY BENEFICIARY(IES):

Name	Address	Relationship	Share to Each

DESIGNATION OF CONTINGENT BENEFICIARY(IES):

Name	Address	Relationship	Share to Each

I authorize the South Dakota Retirement System (SDRS) to release to the South Dakota Bureau of Personnel my address, phone number, and/or email on file for the purpose of the Bureau of Personnel contacting me regarding my health insurance, life insurance, and/or flexible benefits.

I represent that the foregoing information is, to the best of my knowledge and belief, accurate. I agree that to retain coverage, I (we) must abide by the Plan's provisions.

_____ _____
Applicant Signature **Date Signed**