Continuation of Health Care and Dental Coverage Election Form

Name_____ Phone#_____

E-mail Address_____

Home Address _____

City, State, Zip_____

Social Security Number #_____ Date of Birth_____

Institution/Parish/School Name_____

Please select the applicable qualifying event:

- ❑ Separation from employment
- ❑ Reduction of hours
- ❑ Loss of dependent child status
- ❑ Divorce or legal separation
- ❑ Medicare entitlement
- ❑ Death of employee

Date Qualifying Event Occurred: _____

****

Under the terms of the Archdiocese of Boston health insurance plan, you have the option to continue medical coverage, for up to 18 months, by paying the unsubsidized monthly premium, plus an applicable administrative fee of up to 2% of the monthly premium.

To continue health care (medical and/or dental) coverage, please complete the ELECT COVERAGE section below.

If you do not wish to elect to continue any coverage, please complete the DECLINE COVERAGE section below. ***Please Note: If you are currently enrolled in the family plan, you have the option of enrolling in the individual plan for purposes of continuation.***

Please check one of the following:

___ DECLINE COVERAGE - IRREVOCABLE ELECTION: By selecting this option and signing below, I acknowledge my understanding that the decision to decline continuation of the Archdiocese of Boston Health Plan coverage is final and the decision cannot be reversed.

___ ELECT COVERAGE: By selecting this option and signing below, I acknowledge that I understand this notice and am aware of my rights concerning the election of continuation of the Archdiocese of Boston Health Plan coverage.

Coverage Type	Monthly Premium*
❑ Individual Medical	$590.21
❑ Family Medical	$1,518.58
❑ Individual Dental	$43.79
❑ Family Dental	$100.28

*The cost for plan coverage is subject to change. The Archdiocese of Boston Health Benefit Trust and the Plan Administrator retain the right, in its/their sole discretion, to change, amend, or discontinue these benefits.

Please list all members who will continue to be covered by this plan:

Name	Date of Birth	Social Security Number

_____ _____

Staff Member Signature Date

YOUR FIRST PAYMENT IS DUE NO LATER THAN THE 25th OF THE MONTH PRIOR TO THE CONTINUATION OF COVERAGE START DATE.

PLEASE MAKE CHECKS PAYABLE TO: RCAB HEALTH BENEFIT TRUST

RETURN THIS FORM AND PAYMENTS TO:
ARCHDIOCESE OF BOSTON
BENEFITS DEPARTMENT
66 BROOKS DRIVE
BRAINTREE, MA 02184

On the memo line of the check, please indicate the month the payment is being submitted for along with the full name of the participant who has elected COC.

Rev. 10/2011