Request to Elect Critical Illness COBRA

EMPLOYER SECTION

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Plan Administrators (the employer) are responsible for administering COBRA continuation coverage. You may use this form to inform us of the intention of a qualified individual to continue critical illness insurance coverage. Please complete the employer section of this form and have the qualified individual complete the reverse side and forward the completed form to Sun Life Financial, Attn: Worksite, PO Box 419569, Kansas City, MO 64141-6596. T 800.733.7879 F 888.208.2323

This form does not constitute a Notice of COBRA Continuation Rights. If you have questions about your COBRA obligations, please consult your attorney.

Group name _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Employee name _____

Date coverage terminated _____ Date employer was notified of qualifying event _____

Date qualified individual was notified of COBRA rights _____

Qualifying Events *(Please check appropriate box.)*

☐ Employee terminated employment because of voluntary termination, unapproved leave of absence, lay-off or was dismissed for reasons other than gross misconduct: 18 months

☐ Employee's hours were reduced: 18 months

☐ Death of the covered employee: 36 months

☐ Divorce or legal separation of the covered employee from spouse: 36 months

☐ The covered dependent child ceases to be an eligible dependent under the terms of the employer's critical illness plan: 36 months

☐ The occurrence of a second qualifying event. Explain. _____

_____

☐ Extension of the 18-month COBRA continuation of coverage period up to a maximum of 29 months due to disability. *(Certificate of entitlement must be submitted as proof of disability.)*

COBRA benefits will be terminated if premiums are not paid in a timely manner or if other critical illness insurance coverages are obtained.

Employer's signature _____ Date _____

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states except New York. In New York, insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

Sun Life Financial, Attn: Worksite,
PO Box 419569, Kansas City, MO 64141-6596.

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QUALIFIED INDIVIDUAL SECTION

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), employees and/or dependents may have the right to continue insurance beyond the date insurance would otherwise terminate. You should contact your employer concerning your right to continue critical illness insurance coverage under the employer's plan. If you are eligible to continue your critical illness insurance coverage and wish to continue coverage, at your own expense, please complete this form and return it to the employer. This form must also be completed and returned to the employer if continuation of coverage is not elected.

If you or your dependents obtain or are already covered under another critical illness insurance plan (that does not exclude or limit coverage for pre-existing conditions) after the date continuation of coverage has been elected, then COBRA continuation will terminate as of the effective date of the other critical illness insurance plan.

Please print.

Group name			Policy no.	
Participation no.	Account no.		Certificate no.	
Employee name				
Employee's address—Street		City	State	Zip

List all qualified individuals to be covered under the continuation and check the coverages to be continued. *(Any qualified individuals that are not listed will not be insured for continuation of coverage.)* Only those coverages that were in effect immediately prior to the date coverage terminated, can be continued. Use a separate sheet of paper if additional space is needed; sign and attach extra copies.

Qualified Individuals	**Social Security No.**	**Date of Birth**	**Critical Illness**
Employee's name			☐
Spouse's name			☐
Dependent's name			☐
Dependent's name			☐

Are you or your dependents covered under another critical illness insurance plan? ☐ Yes ☐ No

If "Yes," name of insurance company _____ Effective date _____

IMPORTANT! PLEASE SIGN

☐ I am electing to continue critical illness insurance coverage as indicated above for those persons named. I understand that it is my obligation to pay all premiums when due in order to secure and maintain continuation of coverage.

I also agree to notify the employer if I or my dependents become covered under another critical illness insurance plan.

SIGNATURE DATE

☐ I am waiving my rights to continue all critical illness insurance coverage for myself and/or my eligible dependents and do NOT wish to elect continuation of coverage.

If all coverage is being waived for employee and/or dependents, the employee and each adult (18 or over) dependent MUST sign the form.

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE