NOTICE OF INTENT TO ELECT EXTENDED COVERAGE UNDER SOUTH DAKOTA CONTINUATION OR COBRA

NAME:_____
Last First Middle

MAILING ADDRESS:_____
Street City State Zip

SEX
( ) Male ( ) Female

BIRTH DATE:_____

SOCIAL SECURITY #:_____

I elect to continue my health benefits under your health benefit plan as of my _____. _____ Yes _____ No
Qualifying Event

I elect to continue my dependent benefits under the above plan. _____ Yes _____ No

Please list the following information for each person who will be receiving continuation coverage:

Name	Birth Date	Soc. Sec. #

My first payment is enclosed. This payment includes all monthly premiums due as of _____, which is the effective date of my extended coverage. _____ Yes _____ No

You will receive my first payment within 45 calendar days from the date of this notice.
_____ Yes _____ No

Is any applicant for continuation coverage presently covered under another group health care plan or Medicare? _____ Yes _____ No If yes please specify: _____

_____ _____
Signature of Applicant Date

IMPORTANT: We must receive:
1. A completed copy of this notice by _____.
2. Your first payment within 45 calendar days following the date you sign this form. If your payment is not received within the 45 calendar days from the date of this notice, your right to this extended coverage is terminated.

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OFFICE USE ONLY:
Date of Qualifying Event:_____ Date Office Notified:_____
Date of Election Notice:_____