Trustmark
LIFE INSURANCE COMPANY

KANSAS CONTINUATION ELECTION FORM
EMPLOYEE AND/OR SPOUSE AND CHILD(REN)

To Be Used By Employers With Less Than 20 Total Employees

To Be Completed By The Employer

Employee Name _____ Date _____

Social Security No. _____ Group Number _____

Home Address _____ Employer Name _____

_____ Employer Address _____

Last Workday _____ _____

Date Coverage Ends _____ _____

Continuation Event:

- ❒ Termination of Employee or Class Eligibility (Last Work/Eligibility Day)_____
- ❒ Death of Employee (Date of Death) _____
- ❒ Dissolution of Marriage (Date of Decree/Legal Separation) _____
- ❒ Child Attaining Limiting Age or No Longer a Full-Time Student (Birthday)_____
- ❒ The Contract Terminates.

RE: NOTICE OF RIGHT TO CONTINUE COVERAGE

Your Comprehensive Medical Benefits coverage would normally terminate as of the date indicated. State law permits you to continue this coverage for a specified period of time. An explanation of this right is on the reverse side. Please read it carefully.

Whether or not you decide to continue coverage, please complete the section below. If you elect to continue coverage, this form and the **Initial Premium** (shown below) must be returned to Trustmark Life within **31 days** from the date of this notice. Failure to do so will terminate your right to continue coverage. It is recommended that you use **certified mail, return receipt requested.**

The Monthly Premium is based on your coverage as of your termination date. If you elect alternate coverage, the monthly premium will be adjusted. After the Initial premium, payment must be received by Trustmark Life no later than the first day of each month. A late premium payment will be cause to terminate coverage without reinstatement. Premium must be paid by check or money order and made payable to Trustmark Life.

Initial Premium $ _____ Monthly Premium $ _____

_____ _____
Authorized Employee Signature Date of Notice

To Be Completed By The Insured

❒ I elect to continue my Comprehensive Medical Benefits coverage as follows:
(only those insured on the date coverage ends may be included)

- ❒ Employee Only
- ❒ Employee and Spouse
- ❒ Employee, Spouse and Child(ren)
- ❒ Spouse and Child(ren) (Spouse Date of Birth) _____ (Spouse Social Security No.) _____
- ❒ Child(ren) Over Limiting Age (Date of Birth) _____ (Social Security No.) _____

❒ I do NOT elect to continue Comprehensive Medical Benefits coverage for myself and Dependents, if any.

x _____ _____
Employee's Signature Date

_____
Home Address (City, State, Zip Code, if different than above)

Original - Trustmark Life Copy - Employee
G457-238 (TL)

CONTINUATION – AN EXPLANATION OF RIGHTS

State law allows the Comprehensive Medical Benefits coverage to be continued when:

1. Employment or class eligibility is terminated for any reason;
2. The employee dies;
3. The marriage is dissolved or you legally separate;
4. A child reaches the limiting age; or
5. The contract terminates.

Only those persons insured on the date coverage would otherwise end are eligible for continuation. The full premium for such coverage must be paid by the insured electing continuation. Following is an outline of your rights. You should consult your Certificate of Insurance for a detailed explanation of the continuation benefit and your rights thereto. Continuation coverage is subject to all of the exclusions and limitations of the Plan.

QUALIFICATION FOR CONTINUATION

You are eligible to elect continuation coverage if you:

1. Have been insured under the Employers plan for at least 3 months;
2. Are NOT eligible for Medicare;
3. Are NOT eligible under any other similar group insured or self-insured health plan;
4. Are NOT covered by similar group coverage which replaces this plan within 31 days of termination of this plan;
5. Did NOT lose coverage due to failure to pay required premium when due; and
6. Do NOT exercise the conversion privilege.

PERIOD OF CONTINUATION

The maximum continuation period is eighteen (18) months. Continuation will end earlier, however, upon the occurrence of any of the following:

1. Failure to pay premium when due.
2. The person becomes eligible under any other group health plan.
3. The person becomes eligible for Medicare.

NOTICE REQUIREMENTS

You must complete the election form and submit the Initial Premium within 31 days of the date coverage would end. Otherwise, the right to continue is forfeited. Trustmark Life will notify you during the continuation period of any change in the Plan, benefits or premium rates.

PREMIUM

The Monthly Premium is due **on or before** the first day of each month. Premium must be paid by check or money order and mailed to Trustmark Life Insurance Company, [400 Field Drive, Lake Forest, Illinois 60045]

CONVERSION RIGHTS

At the end of the continuation period, you may exercise the conversion privilege. We will send you information regarding the conversion privilege. The first premium must be received by Trustmark Life within thirty-one (31) days after continuation coverage has ended. See your Certificate of Insurance for further information about the Conversion Policy.

Kansas Health Insurance Association

Health insurance coverage may also be available through the Kansas Health Insurance Association. Please contact the Kansas Department of Insurance at 1-800-432-2484.