Form for Switching Plan Options

For involuntary terminations of employment between September 1, 2008 and December 31, 2009

Instructions:

This Form for Switching Plan Options can ONLY be used if you have elected or are electing New Jersey Continuation following an *involuntary* termination of employment occurring between September 1, 2008 and December 31, 2009.

Contact your former employer and ask the following:

1. Does the employer offer a medical plan for active employees other than the plan under which you were covered prior to your termination of employment? If yes, proceed to item 2. If no, you have no opportunity to switch plan options.
2. Is the cost for the alternate plan the same or less than the cost for the plan under which you were covered prior to your termination of employment? If yes, proceed to item 3. If no, you have no opportunity to switch plan options.
3. Ask your former employer for the name of the carrier issuing the alternate plan, the exact plan name of the alternate plan along with information on the applicable copayments, deductible and coinsurance. If the employer is not sure of this information, suggest that he or she ask the broker for these details. The carrier will verify the availability of the alternate plan.

For new elections of New Jersey Continuation the alternate plan will be effective as of the effective date of continuation coverage.

If New Jersey Continuation is already in effect, the alternate plan will be effective as of the start of the first period of coverage on or after this election is received.

I elect New Jersey Continuation coverage for myself and my covered dependents under the alternate plan option as stated below.

I. Terminated Employee Information

Name: ______________________________ SS# ______________________

First MI Last or other identifier

Address ____

Street City State Zip Code

Dates: ____________________ ____________________

Employment Ended Medical Coverage Ended

II. Alternate Plan Election

Name of carrier issuing alternate plan: ______________________________________

Name of alternate plan: ____

Copayment: _________ Deductible: _________ Coinsurance: _________

III. Signature

______________________________________ ______________________

Signature of Terminated Employee Date