

New Jersey Continuation Election Form

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

Instructions:

This Election Form can ONLY be used to elect New Jersey Continuation in the event of an *involuntary* termination of employment occurring between September 1, 2008 and December 31, 2009. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

To elect to continue medical coverage under New Jersey Continuation, the terminated employee must complete the following form and mail it to the former employer. The completed election form must be postmarked **within 30 days** of the date this notice was received.

If medical coverage under New Jersey Continuation is already in effect, do not complete this election form again.

I elect to continue medical coverage for myself and all dependents listed in item II 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

Was the termination an involuntary termination of employment? Yes No

If No, do not submit this form. Contact your former employer for information on New Jersey Continuation.

II. Dependent Information

List all dependents who were covered under your former employer's medical plan on the date before your employment was involuntarily terminated and who you wish to cover under New Jersey Continuation. *Note:* Dependent coverage can ONLY be continued if the former employee elects to continue coverage for him/herself.

Name	Date of Birth	Relationship To employee	SS# or other identifier
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

III. Plan Selection

Check one

Same coverage that was in effect on the day before coverage ended or such other replacement coverage as is currently offered to active employees

Alternate coverage. You must complete the Form for Switching Plan Options

IV. Signature

Signature of Terminated Employee

Date