



# Arkansas Group Health Coverage Employer Notice of Occurrence of Qualifying Event for the Right to Continuation Coverage

### Employee/Dependent Information

Name of Employee		
Name of Dependent (Only If dependent is continuing coverage)		
Address		
City	State	ZIP Code
Employee's ID Number	Date of Qualifying Event/ Termination of coverage	

### Employer Information:

Name of Employer		
Address		
City	State	ZIP Code
Effective Date of Coverage	Control No./Group No.	

This continuation of group health coverage is available only when **COBRA** continuation does not apply.

The above employee/dependent(s) who has been insured continuously under the policy for **3 months** prior to loss of coverage is eligible for continuation because of loss of coverage due to the following event: (check one):

- 1. Termination of employment (other than for gross misconduct), loss of eligibility due to reduced hours.
- 2. Divorce or legal separation.

Continuation is **not available** to any person who:

- is or could be covered by any other group coverage (insured or uninsured) within 31 days of the date of termination of employment;
- had his or her insurance terminated because of fraud or failure to pay; or
- chooses federal COBRA in favor of Arkansas state continuation.

The group health coverage under which the above individual(s) has been covered will end because of the reason and on the **Date of the Qualifying Event** indicated above. An election form to continue coverage will be sent by Aetna to the group member. If the group member elects continuation and pays the premium, elected benefits will be reactivated without lapse in coverage.

A. Immediately after the above event or the termination of coverage, whichever is later, you must complete and return this form to:

**Aetna  
Plan Sponsor Services - State Continuation  
9000 Southside Blvd.  
Building 100, 8<sup>th</sup> Floor  
Jacksonville, FL 32256                      Fax No. 860-907-3300**

B. Immediately upon receipt, Aetna will send an Election Notice via certified mail, return receipt requested, directly to the member.

C. If the group member wishes continued coverage, s/he must provide Aetna with both written notice of election and payment of the initial group premium within:

- **10 days (as shown by postmark)** after receiving the election and premium notice.

### Name and address of all other group members (covered spouse and covered dependent children).

Name	Address	City	State	ZIP Code