aetna®

Florida 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 under the group policy 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. The employee's death. ☐ 3. Divorce or legal separation. ☐ 4. Loss of dependent status.

☐ 5. Loss of dependent coverage when employee becomes entitled to Medicare.

☐ 6. A retiree or dependent of retiree losing coverage within 1 year before or after the commencement of proceedings under Title 11 (bankruptcy) United States Code by the employer from whose employment the covered employee retired.
Date of loss of coverage_____

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
- is eligible for federal COBRA.

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. Within 63 days 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, 8th 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:
   - **30 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