Kentucky Group Health Coverage

Employer Notice of Occurrence of Qualifying Event for the Right to Continuation Coverage

Employee Information			Employer Information		
Employee Name			Employer Name		
Address			Address		
City	State	ZIP Code	City	State	ZIP Code
Employee Identification Number	**Date of Qualifying Event**/Termination of Coverage		Control Number	Date	

This Continuation of Group Health Coverage is **available only when COBRA continuation does not apply**. The above employee and/or dependent(s) is eligible for this continuation because of loss of coverage due to the following event:

Check one:

- ☐ 1. Termination of group membership/coverage for any reason including termination for gross misconduct.
- ☐ 2. The employee's death.
- ☐ 3. Divorce.
- ☐ 4. Dependent children who reach the limiting age.
- ☐ 5. Dependents who marry.

The group health coverage under which the above individual(s) have been covered for at **least 3 months** will cease 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, the employer must complete and return this form to the applicable address listed below.

Send to:
Aetna
Plan Sponsor Services
Attn: Kentucky State Continuation
9000 Southside Blvd.
Building 100, 8th Floor
Jacksonville FL 32231-4129

The group member has a maximum of **91 days** from the date of the event with which to elect continuation coverage, therefore, ***it is important that this form be returned to Aetna as soon as possible after any event listed above***.

B. Immediately upon receipt, Aetna will send an Election Form directly to the group member.

C. If the group member wishes continued coverage, s/he must provide Aetna with both written notice of election and payment of the group premium within **91 days** of the later of:
- The qualifying event, or
- The date coverage under the employer's plan terminated.

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

Name	Address	City	State	ZIP Code
Name	Address	City	State	ZIP Code
Name	Address	City	State	ZIP Code
Name	Address	City	State	ZIP Code