aetna®

Rhode Island Group Health Coverage
Employer Notice of Occurrence of Qualifying Event for the Right to Continuation Coverage

Employee/Dependent Information			Employer Information:		
Name of Employee			**Name of Employer**		
Name of Dependent (Only If dependent is continuing coverage)					
Address			**Address**		
City	**State**	**ZIP Code**	**City**	**State**	**ZIP Code**
Employee's ID Number	**Date of Qualifying Event/ Termination of coverage**		**Effective Date of Coverage**	**Control No./Group No.**	

This continuation of group health coverage is available in addition to COBRA. The member must choose either COBRA or Rhode Island state continuation. Rhode Island state continuation applies to medical coverage and to standalone dental and vision.

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. Involuntary lay –off ☐ 2. The employee's death. ☐ 3. 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;
- chooses federal COBRA over 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, 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