

HEALTH BENEFITS CONTINUATION PLAN ENROLLMENT FORM

University of Texas System Medical Foundation

Employee Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Branch: UTSMF

Qualifying Event: **Termination**

List Eligible Persons to Be Covered: **Persons Previously Covered Only:**

Last Name	First	MI	Date of Birth	Sex	Social Security No.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

<u>Plan Description :</u>	<u>Coverage Level:</u>	<u>Monthly Premium:</u>
<b>MHHNP (EPO) Medical Plan</b>	<b>Employee Only</b>	<b>\$ 320.88</b>
	<b>Employee &amp; Child(ren)</b>	<b>\$ 529.30</b>
	<b>Employee &amp; Spouse</b>	<b>\$ 671.98</b>
	<b>Employee &amp; Family</b>	<b>\$ 932.76</b>

I HEREBY REQUEST ENROLLMENT IN THE HEALTH BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS LISTED ON THIS FORM AND AGREE TO PAY THE PREMIUM AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE A CONTINUED DEPENDENT OR I BECOME COVERED UNDER ANOTHER GROUP HEALTH/DENTAL/VISION PLAN, BECOME ENTITLED TO MEDICARE, OR ON THE DATE WHICH THE GROUP HEALTH/DENTAL/VISION PLAN ENDS. I ALSO UNDERSTAND THAT IF I BECOME DISABLED WITHIN SIXTY (60) DAYS OF THE COBRA QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE, AND THAT ANY BREAK IN CONTINUED COVERAGE OF MORE THAN SIXTY-THREE (63) DAYS MAY CAUSE LOSS OF COVERAGE "PORTABILITY".

\_\_\_\_\_  
Signature of Primary Qualifying Beneficiary

\_\_\_\_\_  
Date

Please mail completed form w/ premium payable to:  
U.T. System Medical Foundation  
6431 Fannin Street, Suite JLL-310  
Houston, TX 77030  
Tel (713) 500-5243 / Fax (713) 500-0699