

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.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Plan Description :	Coverage Level:	Monthly Premium:
<u>PHCS (PPO) Medical Plan</u>	Employee Only	\$ 385.06
	Employee & Child(ren)	\$ 635.16
	Employee & Spouse	\$ 806.37
	Employee & Family	\$ 1,119.31

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) 500-5247 / Fax (713) 500-0699