

# Utah State Continuation

## Notice of Right to Continue Health Insurance & Certificate of Health Plan Coverage

*Please read carefully*

*If you have been covered by a Utah employer's group medical insurance policy for at least 3 months, then you may continue that same benefit for up to 12 months, but you must pay the total monthly premium.*

Employer Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date employee first covered by insurance: \_\_\_\_\_

Reason insurance will stop (voluntary termination, involuntary termination, retirement, death, divorce or legal separation, loss of dependent status, sabbatical, any disability, leave of absence, or reduction of hours)

Date of above event \_\_\_\_\_

Date insurance stops: \_\_\_\_\_

Monthly insurance premium for person(s) losing coverage (as shown on bill from insurance company)

# Notice of Right to Continue Health Insurance & Certificate of Health Plan Coverage (Continued)

**This notice explains your legal rights and obligations as governed by Utah law.** Because of which happened on , your coverage under the company's group health insurance plan would normally cease; however, under the terms of UCA 31A-22-722 you are entitled to continue the health insurance coverage at your expense under the company's group medical coverage at group rates. Under the present circumstances, your coverage will have ceased as of unless you notify the company in writing of your election to purchase continued coverage and you also make the necessary premium payments on a timely basis.

Continued coverage offered to you is and will be identical to that offered by the company to its other employees (and their dependents) of the same employee classification. **You may continue coverage for up to 12 months.**

Even if you elect to continue coverage at your expense, certain events may cut short the 12 month period. These events are:

- (a) If the company were to no longer provide any group health coverage to any of its employees;
- (b) If the premium for your continuation coverage were not paid by you within the time permitted;
- (c) If you were to become an employee covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition which would apply to you; or
- (d) If you establish residence outside of Utah; or
- (e) You violate a material condition of the insurance contract.

There is no requirement to show insurability in order to elect the continued coverage under the company's group insurance policy. You must, however, have been covered at the time the "qualifying event" occurred which made you no longer eligible under the regular terms of the plan. The right to elect continuing coverage may be exercised individually by any person eligible or as a family unit.

The provisions of the coverage offered under the plan at this time are the same as you had prior to the Qualifying Event. If you have questions regarding benefits available to you under the plan, please refer to the information provided to you when you were an active employee or you may request a copy of the plan provisions from .

You have sixty (60) days from the date your coverage would otherwise end to make an election to continue coverage. Your election must be in writing and returned to the company within that time. Please use the attached Election Form to do so. If you make the election on a timely basis and submit the initial premium payment as described below on a timely basis, your coverage will be reinstated effective as if the indicated event had not caused a termination. You may expect the insurance carrier to withhold action on any claims or withhold services except on a fee basis until such time as you have elected coverage and paid the appropriate premium.

In the event that you elect to continue coverage, you will be required to remit to the company the premium necessary to cover the period from the date that your coverage would have terminated, as result of the indicated event, through and including the end of the month in which the initial payment is made. You must start initial premium payment as described above with your election. Thereafter, each month's premium must be in the hands of \_\_\_\_\_ on or before the first day of each month in order for the coverage to continue for that month. All premium payments (including the initial one) must be in the form of money order or cashier's check unless otherwise approved in writing by \_\_\_\_\_. Failure to make the initial premium payment on time will result in the termination of your coverage as of the date of \_\_\_\_\_. Failure to make subsequent monthly premium payments on time will permanently terminate the continued coverage as of the end of the month for which premium was paid by you. No reinstatement provisions exist under the law. If you prefer to make your payments in advance for the full 12 months, you may do so.

If you have further questions about the provisions of this law and its effect on you, the timing of elections or payments, or the amount of the premium, please contact \_\_\_\_\_.

**IF YOU HAVE ANY CHANGE IN MARITAL STATUS, YOU DIE, YOU OR YOUR SPOUSE, OR ANY OF YOUR CHILDREN HAVE CHANGED ADDRESSES, OR YOUR CHILD CEASES TO BE A DEPENDENT CHILD AS DEFINED BY THE COMPANY'S THEN CURRENT HEALTH INSURANCE PROGRAM BY WHICH YOU ARE COVERED, THE COMPANY MUST BE NOTIFIED IMMEDIATELY. If notice is delayed beyond 30 days, certain rights for continued coverage of the person affected by the change may cease to exist.**

You must notify \_\_\_\_\_ and the insurance carrier of a birth or adoption within thirty (30) days, in order for the child to be covered.

Your rights under Utah law are more restricted than COBRA as to eligibility, the length of coverage (maximum of twelve months) and the election period (30 days).

Unless you request further information, you will receive no other communication from the company regarding this matter. Therefore, you may wish to retain this notice for future reference.

**Certificate of Group Health Plan Coverage**

As required by HIPAA

You were first covered by the group medical insurance plan for  
on \_\_\_\_\_ . For your information- consider this a Certificate of Group Health Plan Coverage.  
It is being sent to you as a result of the Health Insurance Portability and Accountability Act which was  
passed by Congress and signed into law by President Clinton in 1996. The provisions of the Act are now  
becoming effective.

Under the Act, group health plans are allowed to have pre -existing condition exclusion clauses up  
to 12 months (18 months for late entrants). However, you may receive credit toward eliminating all or  
part of the “PEC” period by presenting yo ur new employer or insurer with this certificate. The Certificate  
will not apply IF YOU HAVE HAD A BREAK IN COVERAGE OF MORE THAN 62 DAYS since the  
end of your coverage noted on the Certificate. Waiting periods for eligibility at a new job do not count  
toward the 62 days.

**Election Form**

The monthly premium will be: \$

Payable to:

**Note:** Money order or Cashier’s Check ONLY!

This must be received by (30 days from date you receive this notice):

I elect to continue my group medical insurance.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_