

Request for Continuation of Eligibility

Personal Plans

Instructions for completing the form

General information. To be completed by employee.

Only choose one:

A. Continuation of eligibility. Complete this section if your employment has ended with a Southern Baptist church or entity and you are actively seeking another full-time salaried position with another Southern Baptist church or entity or will be attending seminary.

Or

B. Medical and/or dental continuation plan. This section should be completed if any of the following apply:

- You have left Southern Baptist denominational work and want to continue medical and/or dental coverage for yourself only or yourself and your family.
- Loss of dependent child status (children who reach the maximum age limit under the plan or marry).
- You are divorced or legally separated from the employee.

GENERAL INFORMATION

Participant name: _____ Social Security number (last four digits): _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Home telephone: (_____) _____ Birth date: ____/____/____

A. COVERAGE CONTINUATION

Note: Do not use this form to report termination of service due to medical reasons which might qualify you to receive disability benefits or to report new employer change.

I understand that this extension, if granted, will permit me to continue my participation in the Personal Plans medical and/or dental plans on the present basis for not more than twelve (12) months after the above service ended.

I also understand any Personal Plans disability coverage I have will cease to be effective the last day worked. If I notify GuideStone within 30 days of returning to full-time work with a Southern Baptist church, agency or institution and no more than twelve (12) months has passed since my disability coverage ceased, I can resume disability coverage without providing evidence of good health.

Participant signature: _____ Date: ____/____/____

I was last serving on a full time basis.

Name of church or denominational entity: _____ Telephone number: (_____) _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

When did/will this full-time service end? (Give exact date) ____/____/____

Are you leaving denominational work permanently? Yes No

Are you actively seeking another position with a Southern Baptist church or agency? Yes No

Are you a seminary student? Yes No

If "yes," provide the following information:

Name of school attending: _____ Date enrollment began: ____/____/____

School's address: _____

City: _____ State: _____ ZIP Code: _____

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B. REQUEST FOR MEDICAL AND/OR DENTAL CONTINUATION

Please check which coverage is to be continued: Medical Dental

I understand that no evidence of good health is required, but this request must be made within 60 days of the date my Personal Plans medical and/or dental plan terminates. I further understand that this request, if approved, will permit me (and my eligible dependents, if applicable) to continue participation in the Personal Plans medical and/or dental plan for not more than 18 or 36 months (dependent on the reason(s)* for termination of coverage) after the date I became ineligible for medical and/or dental coverage. I understand that there will be a separate monthly charge if only a dependent is applying for medical and/or dental continuation.

*18 Months

- Termination of employment.
- Loss of coverage due to reduction in the number of hours worked.

*36 Months

- Divorce or legal separation from employee.
- Loss of dependent child status (e.g., children who reach the maximum age limit under the plan or marry).

Participant signature: _____

Request medical continuation for: Employee only Employee and dependent(s) Dependent only

Request dental continuation for: Employee only Employee and dependent(s) Dependent only

If continuation is for a dependent only, complete the following:

Dependent name: _____ Birth date: ____/____/____

Dependent Social Security number (last four digits): _____ Telephone number: (_____) _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Date became ineligible for medical and/or dental: ____/____/____

Eligibility for medical and/or dental coverage ceased because: _____

GUIDESTONE USE ONLY

Approved by GuideStone Financial Resources

Approved by: _____ Date: ____/____/____

Return completed form to: Insurance Operations — Personal Plans
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498

Or fax to: 214-720-4676