

# Request for Medical and/or Dental Continuation Group Plans

## APPLICANT INFORMATION

Employee name: \_\_\_\_\_ Social Security number (last four digits): \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Employer name: \_\_\_\_\_ Employer number: \_\_\_\_\_

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 coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_

Eligibility for medical and/or dental coverage ceased because: \_\_\_\_\_

I understand that this request must be made within 60 days of the date my Group 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 Group 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.
- Elimination of eligible class of employees.

### \* 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).

**I agree to promptly notify the above named employer if I become covered as an employee or dependent under another group medical and/or dental plan. I further understand all other coverage will cease (or ceased) on the date I became ineligible for such coverages.**

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer's authorized representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## GUIDESTONE USE ONLY

Approved by: \_\_\_\_\_ HIPAA: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**Or fax to:** 214-720-2105

