

# Request for Continuation of Eligibility

## Personal Plans

### Instructions for completing the form

**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.**

**A. Continuation of eligibility.** Complete Section A if any of the following apply:

- Your employment has ended with a Southern Baptist church or entity and you are actively seeking another full-time salaried position with a Southern Baptist church or entity.
- You are no longer a seminary student due to graduation or are terminating your student status and are actively seeking a full time salaried position with a Southern Baptist church or entity.

**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).
- You are divorced or legally separated from the employee.
- You are no longer a seminary student and are not seeking Southern Baptist employment.

### GENERAL INFORMATION To be completed by employee

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

Home address: \_\_\_\_\_

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

Home telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### A. REQUEST FOR CONTINUATION OF ELIGIBILITY (while seeking Southern Baptist employment)

I was last serving on a full-time basis.  My student status has ended at a qualified seminary.

When did this full-time service/student status end? \_\_\_\_/\_\_\_\_/\_\_\_\_

I am seeking a position with a Southern Baptist church or agency.

Please check which coverage is to be continued:  Life  AD&D  Medical  Dental

Request continuation for:  Employee only  Employee and dependents

Are you a seminary student?  Yes  No If attending seminary please provide:

Name of school attending: \_\_\_\_\_ Date enrollment began: \_\_\_\_/\_\_\_\_/\_\_\_\_

School's address: \_\_\_\_\_

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

I understand that this extension, if granted, will permit me to continue my participation in the plans I have chosen on the present basis for not more than twelve (12) months after the full-time service or student status 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**B. REQUEST FOR MEDICAL AND/OR DENTAL CONTINUATION (due to loss of eligibility)**

- |   |  |
|---|--|
| <input type="checkbox"/> 18 Months*   | <input type="checkbox"/> 36 Months*  |
| <input type="checkbox"/> Termination of employment.                                       | <input type="checkbox"/> Divorce or legal separation from employee.  |
| <input type="checkbox"/> Loss of coverage due to reduction in the number of hours worked. | <input type="checkbox"/> Loss of dependent child status (e.g., children who reach the maximum age limit under the plan). |
| <input type="checkbox"/> No longer seminary student                                       | Date became ineligible _____   |
| Date became ineligible _____  |  |

- 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: \_\_\_\_\_

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.

Participant signature: \_\_\_\_\_

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**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