

VISION SERVICE PLAN  
 ATTN: COBRA  
 P.O. BOX 997100  
 SACRAMENTO, CA 95899-7100

ELECTION OF CONTINUED VISION COVERAGE  
 (as required under P.L. 99-272)

Please print or type

Name of Group: UCSF Residents & Fellows Effective Date of Coverage:  / /

Reason for Qualification Under P.L. 99-272:

Termination of Employment     Legal Separation or Divorce     Surviving Spouse     Loss of Child's Dependent Status     Reduction of Hours worked

Date of Event:  / /     / /     / /     / /     / /

Social Security #	Last Name	First Name	Middle Initial	Sex	Date of Birth	Status
	Applicant:			<input type="checkbox"/> M <input type="checkbox"/> F	Mo Day Yr / /	<input type="checkbox"/> Married <input type="checkbox"/> Single
	Address:					
	Daytime Phone # ( )					

Please list all your dependents to be enrolled:

Last Name	First Name	M.I.	Date of Birth Mo Day Yr
SPOUSE			
			/ /
Children (include surname if different)			
			/ /
			/ /
			/ /

Last Name	First Name	M.I.	Date of Birth Mo Day Yr
			/ /
			/ /
			/ /
			/ /

Insured Employee's Name                      Social Security Number of Insured:                      Relationship to Insured Employee:

Federal law permits an employee whose group insurance terminated due to reduction of work hours or termination of employment (other than for gross misconduct) to continue their insurance coverage for themselves and/or their insured dependents for up to 18 months. A surviving child(ren) or spouse, a divorced or legally separated spouse and child(ren) no longer eligible for group insurance by reason of age or marriage may also elect continuation for up to 36 months. Coverage may not be continued if the person is eligible for Medicare or other group coverage, if the group plan terminates, or if the person stops paying for coverage.

In order to continue your vision insurance benefits under the group plan, you will be required to pay the full monthly charge. This amount may change in accordance with rate changes for the group plan. If payment is not received by VSP by the 30<sup>th</sup> of the month, coverage will cease and may not be reinstated.

To continue group coverage, this form must be returned to VSP within 60 days of receipt of this form. If you do not return this form within 60 days, it is assumed that you have elected not to continue under the group plan. After the 60 days have elapsed, you will not be permitted to elect continued coverage.

- I do not elect to continue my vision insurance under the group plan.
- I elect to continue my vision insurance under the group plan at a cost of \$ \_\_\_\_\_ per month.
- Enclosed is my check for \_\_\_\_\_ months of coverage, payable to VSP.
- My check will follow within 45 days.

NOTE: You must advise VSP in writing in the event you become eligible for vision care under another group plan or Medicare.

I certify that I am not covered under any other group vision insurance plan at this time, including Medicare.

Signature of Applicant

Signature of Dependent