

## **PLEASE USE BLACK INK**

Group Name:

## EXTENDED COVERAGE DESIGNATION FORM

	Group Number:	SubGroup:
Coverage applied for: PPO 90/70  PPO 80/60	☐ POS 80/60 %	□ POS 80/70
Please extend coverage for:	se Child/Children	
Employee's Social Security Number:	SN, If other than employee:	Effective Date:
Last Name:	First Name:	MI:
Home Address:		
City:	State: Z	ip Code:
		,,p 6646.
Home Phone:	Date of Birth:	Coverage To Extend:  Dental Yes No
		Dental Yes No  Medical Yes No
Please Check Reason for Cove	rage Maximum Covera	age Allowed
Termination/Retirement	18 months	S
Reduction of hours (less than	30 hrs per week) 18 months	S
Employee Death	36 months	
Divorce or Legal Separation  Cessation of Dependent Stat	36 months us 36 months	
occount of Dependent of at	do montrix	
Please compl	ete page 2 for covered de	ependents.
EMPLOYEE SIGNATURE		Date:
OR		
EMPLOYER SIGNATURE		Date:

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Group Name:			Social Security Number:	
Last Name:		First Name:	MI:	
	Dia a a a a a a a a a a a a a a a a a a			
	Please comp	plete the above information		
Last Name:		First Name:	MI:	
p				
u Social Security Number:	Date of Birth:	Sex:	Coverage Applied For:  Dental Yes No	0
e		Female   Male	Medical Yes No	
Last Name:		First Name:	MI:	
С				
h Social Security Number:	Date of Birth:	Sex:	Handicapped? Coverage Applied For:	
d		Female	Yes Dental Yes No	
		Male	No Medical Yes No	0
Last Name:		First Name:	MI:	
Last Name:		First Name:		
С	Date of Birth:	Sex:	Handicapped? Coverage Applied For:	0
C	Date of Birth:			
C h Social Security Number:	Date of Birth:	Sex:	Handicapped? Coverage Applied For:  Yes Dental Yes No	
C h Social Security Number:	Date of Birth:	Sex: Female Male	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No	
C h i Social Security Number: I d Last Name:	Date of Birth:	Sex:	Handicapped? Coverage Applied For:  Yes Dental Yes No	
C h Social Security Number: I d Last Name:		Sex: Female Male  First Name:	Handicapped? Coverage Applied For:  Yes Dental Yes No Medical Yes No Mi:	
C h Social Security Number:  Last Name:  C h  Social Security Number:	Date of Birth:  Date of Birth:	Sex: Female Male	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No	0
C h Social Security Number: I d Last Name:		Sex: Female Male  First Name: Sex:	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No MI:  Handicapped? Coverage Applied For:	0
C h Social Security Number:  Last Name:  C h  Social Security Number:		Sex:  Female  Male  First Name:  Sex:  Female	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No MI:  Handicapped? Coverage Applied For: Yes Dental Yes No	0
C h Social Security Number:  Last Name:  C h  Social Security Number:		Sex:  Female  Male  First Name:  Sex:  Female	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No MI:  Handicapped? Coverage Applied For: Yes Dental Yes No	0
C		Sex:   Female   Male     Male     Sex:   First Name:     Sex:   Female   Male     Male	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No MI:  Handicapped? Coverage Applied For: Yes Dental Yes No No Medical Yes No	0
C   Social Security Number:		Sex:   Female   Male     Male     Sex:   First Name:     Sex:   Female   Male     Male	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No MI:  Handicapped? Coverage Applied For: Yes Dental Yes No No Medical Yes No	0
C h Social Security Number: I d Last Name: C h Social Security Number: I d Last Name: C h Last Name:	Date of Birth:	Sex:   Female   Male     Male     First Name:   Female   Male     Female   Male     First Name:   First Name:     First Name:   First Name:     First Name:   First Name:     Female   First Name:     First Name:   First Name:     Female   First Name:     First Name:   First Na	Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No MI:  Handicapped? Coverage Applied For:  Yes Dental Yes No No Medical Yes No Mi:  MI:  MI:  MI:  MI:  MI:  MI:  MI:	000000000000000000000000000000000000000

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