CIGNA Health and Life Insurance Company (CHLIC)
Hospital Supplemental Continuation Request Form
365 Plus Plan

Insured individuals and their currently covered eligible dependents may elect to continue their Group Hospital Supplemental coverage from the date employment terminates. Coverage may continue for 18 months from the qualifying event. The individual who elects to continue coverage is required to pay the full monthly premium on the first of each month. Failure to do so will result in the termination of the continuation provision.
PLEASE NOTE: Termination Notices are NOT sent. REMITTING THE PREMIUM IS THE EMPLOYEE'S SOLE RESPONSIBILITY; THERE IS NO DIRECT COMPANY BILLING. If you will be receiving a retirement check from the State you may elect to have your monthly premium deducted from your check. Please contact CHLIC at 800.888.5256 for the Payroll Deduction Authorization Form and additional information.

I elect to continue the following coverage:

(Premiums for the entire year are based on your age as of January 1st)

	Employee Only	Employee & Family
1. Option I	( ) $_____	( ) $_____
2. Option II	( ) $_____	( ) $_____
3. Option III	( ) $_____	( ) $_____

Retired Employee's Name _____ **Date of Birth** _____

Spouse's Name _____ **Date of Birth** _____

Dependent's Name _____ **Date of Birth** _____

Dependent's Name _____ **Date of Birth** _____

For Office Use Only:

Dept Code_____

App # _____

Old Plan _____

Credit _____

Check # _____

Received _____

Check Amt _____

Premium_____

Paid to Date _____

Effective _____

Mailing Address: _____
Street or P.O. Box Number

_____
City **State** **Zip**

Phone Number: (____)_____ **Monthly Premium Rate: $**_____

Social Security No.: _____ **Date Employment Terminated:** _____/_____/_____

Date Form Completed: _____ **Signature:** _____

PLEASE RETURN THIS FORM AND YOUR FIRST CHECK TO: **CHLIC**
P.O. Box 40926
Jacksonville, Fl 32203-0926