

CONTINUATION OF MEDICAL AND/OR DENTAL COVERAGE /AND/OR  
FLEXIBLE SPENDING ACCOUNTS

BCBS Medical Elections	Total Premiums	Check Preference
Individual Only	\$ 477	_____
Individual + Spouse	\$ 957	_____
Individual + Children	\$ 837	_____
Individual + Family	\$ 1,197	_____

DR Dental Elections	Total Premiums	Check Preference
Individual Only	\$ 25	_____
Individual + One	\$ 67	_____
Individual + Family	\$ 80	_____

QCD Dental Elections - Red Plan		
Individual or Family	\$ 8	_____

QCD Dental Elections - White Plan		
Individual Only	\$ 23.95	_____
Individual + One	\$ 49.95	_____
Individual + Family	\$ 74.95	_____

Flexible Spending Account	Continued Amount
Unreimbursed Medical (URM)	_____
<b>TOTAL MONTHLY PREMIUM DUE</b>	
	\$ _____

**Health/Dental** - I would like to continue health and/or dental coverage as noted above with the Baylor University group plan effective \_\_\_\_\_. I understand this coverage will continue until I am (we are) covered with a comparable plan, Medicare or 18 months from the effective date, whichever comes first. It is my responsibility to notify Baylor University immediately should I become eligible for another insurance coverage.

The above noted rates are subject to change. I understand Baylor will bill me on the first day of each month and payment is due by the 10th of each month. (Example: October premiums are billed October 1 and are due by October 10th).

**Flexible Spending Account** - I would like to continue URM as noted above with the Baylor University group plan effective \_\_\_\_\_. I understand that I am eligible to continue until the end of the plan year in which the qualifying event occurs. (December 20XX)

Please send the monthly bills to: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone #: \_\_\_\_\_

\_\_\_\_\_  
**Signature** **Baylor ID No.** **Date**

RETURN THIS FORM TO: Baylor University  
 Attention: Human Resources  
 One Bear Place # 97053  
 Waco, TX 76798-7053  
 Fax: 254.710.3819