CONTINUATION OF MEDICAL AND/OR DENTAL COVERAGE

EMPLOYEE INFORMATION

Name: _____ BUID: _____

Phone: _____ Email: _____

Billing Address: _____
Street Apt # City State Zip

2015 Health Plans and Monthly Premiums *(Plan stays the same as prior to Continuation of Coverage event)*

Who is electing to continue medical benefits? ☐ Employee or ☐ Spouse or Dependent(s)
Spouse or Dependent Name(s): _____

Check One	**Blue Cross PPO (BlueChoice)**	**Blue Cross HDHP +HSA**
Individual Only	☐ $ 548	☐ $ 458
Individual + Spouse	☐ $ 1,097	☐ $ 917
Individual + Children	☐ $ 958	☐ $ 808
Individual + Family	☐ $ 1,373	☐ $ 1,148

2015 Dental Plans and Monthly Premiums *(Plan stays the same as prior to Continuation of Coverage event)*

Who is electing to continue dental benefits? ☐ Employee or ☐ Spouse or Dependent(s)
Spouse or Dependent Name(s): _____

Check One	**DR Dental**	**MetLife Dental Plan**
Individual Only	☐ $ 41	☐ $ 24
Individual + One	☐ $ 87	☐ $ 48
Individual + Family	☐ $ 107	☐ $ 90

Flexible Spending Account (Employee Continuation Only)

Unreimbursed Medical (URM) Continued Amount: $ _____

TOTAL MONTHLY PREMIUM DUE $ 0

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 (36 months for dependent only coverage), whichever comes first. It is my responsibility to notify Baylor University immediately should I become eligible for another insurance coverage.

If you are aware of the date that you will no longer require continued coverage for medical and/or dental indicate date here: Medical _____ Dental _____. **If a date is entered, your continuation of coverage will automatically be canceled on the date entered**.

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)

_____ _____
Signature (Employee/Retiree) **Date**

_____ _____ _____
Signature (Spouse/Dependent – For dependent only coverage) **Date** **SSN**

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