Request for Medical and/or Dental Continuation
Group Plans

Return completed form to: Insurance Operations — Group Plans
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498

APPLICANT INFORMATION

Employee name: _____ Social Security number: _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Employer name: _____ Employer number: _____

Request medical continuation for: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent only

Request dental continuation for: ☐ Employee only ☐ Employee and dependent(s) ☐ Dependent only

If continuation is for a dependent only, complete the following:

Dependent name: _____ Birth date: _____/_____/_____

Dependent Social Security number: _____ Telephone number: (_____) _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Date became ineligible for medical and/or dental coverage: _____/_____/_____

Eligibility for medical and/or dental coverage ceased because: _____

I understand that this request must be made within 31 days of the date my Group Plans medical and/or dental plan terminates. I further understand that this request, if approved, will permit me (and my eligible dependents, if applicable) to continue participation in the Group Plans medical and/or dental plan for not more than 18 or 36 months (dependent on the reason(s)* for termination of coverage) after the date I became ineligible for medical and/or dental coverage. I understand that there will be a separate monthly charge if only a dependent is applying for medical and/or dental continuation.

* 18 Months

- Termination of employment.
- Loss of coverage due to reduction in the number of hours worked.
- Elimination of eligible class of employees.

* 36 Months

- Divorce or legal separation from employee.
- Loss of dependent child status (e.g., children who reach the maximum age limit under the plan or marry).

I agree to promptly notify the above named employer if I become covered as an employee or dependent under another group medical and/or dental plan. I further understand all other coverage will cease (or ceased) on the date I became ineligible for such coverages.

Applicant's signature: _____ Date: _____/_____/_____

Employer's authorized representative: _____ Date: _____/_____/_____

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Approved by: _____ HIPAA: _____ Date: _____/_____/_____

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