ILLINOIS NOTICE OF CONTINUATION RIGHT

DATE:_____

EMPLOYER: _____ POLICY NUMBER: _____

EMPLOYEE: _____ SOCIAL SECURITY NO: _____

DATE OF TERMINATION OF GROUP INSURANCE: _____

MONTHLY MEDICAL PREMIUM: _____

You are eligible to continue your medical benefits under the Group Policy for 12 months past your termination date if:

1. You have been covered by Group insurance continuously for 3 months immediately prior to the date the coverage would terminate; and

2. You do not become covered by any other Group coverage providing hospital, surgical, or medical coverage, that you were not covered under while you were insured with your employer; and

3. You are not eligible for Medicare; and

4. You do not exercise your Conversion Privilege that is available under your Group insurance; and

5. You have not been fired from your job because:
   a. you committed a felony in connection with your work; or
   b. you stole from your employer.
   Your employer must not have been responsible for your actions in any way. You must have either admitted your guilt or been convicted by a court for the act.

If you meet the above conditions, and desire to continue your medical benefits, you must return this signed form and the first months premium to us, your previous employer, within 30 days from the date of this notice.

See the Continuation of Health Coverage after Termination of Employment page in your certificate booklet for a more detailed explanation.

_____ _____

Date Signature