Department of Defense Nonappropriated Fund Health Benefits Program (DOD)
Group Health Benefits Temporary Continuation of Coverage Application

Employer Section (Please provide the following information necessary to ensure proper processing of application.)

1. To: Eligible Continuee Applicant's Name			1. From: Employer **DEPARTMENT OF DEFENSE (DOD NAF HBP) - CNIC**
3. Address			
4. City			5. State / 6. ZIP
7. Suffix **15**	Account	Plan	8. Date Applicant's Group Insurance Terminates
Employer's Authorized Signature *(Human Resources Office)*			

Temporary Continuation of Group Health coverage is available to you due to the following:

☐ 1. The employee's termination of employment (includes retirement or layoff) or loss of eligibility due to reduction in hours on _____.
☐ 2. The employee's death on _____.
☐ 3. The employee's divorce or legal separation effective _____ .
☐ 4. A dependent child has ceased to be an eligible dependent (e.g. has reached limiting eligibility age under the Group Health Policy) as of _____.
☐ 5. Loss of employment due to disability.

Note: If you are Medicare eligible at the time of the qualifying event, you are not eligible for TCC coverage.

The Group Health coverage under which you have been covered will cease because of the reason and on the date indicated above unless you comply with requirements that follow:

Prior to _____ (which is 60 days after the date coverage ceases), you must complete the Direct Billing Enrollment Request below if you want continuation. Return it to the address on the reverse side of this form along with your check to cover the initial payment.

THE CHECK FOR THIS INITIAL PAYMENT MUST COVER THE NUMBER OF FULL MONTHS FROM THE ABOVE INSURANCE TERMINATION DATE TO THE TIME OF YOUR ELECTION.

Coverage Available (circle applicable coverage): Medical FSA

The initial monthly cost for Continued Group Health Coverage is: Single $_____ Family $_____

FSA Monthly Contribution Amount: $ _____

NOTE: Rates are subject to audit by Aetna or Department of Defense. (Any adjustments in premium will be reflected on your next monthly statement.)

After the initial payment, you must submit the same monthly payment as billed, until you have been advised of a general change for all participants. If you fail to make the billed monthly payment within 31 days of its due date, your coverage will cease on that date and cannot be reinstated.

If you are enrolled in a Healthcare Flexible Spending Account (FSA) and wish to continue, it may usually only be continued through the end of the current plan year on an after tax basis. **Make Check Payable To: AETNA LIFE INS. CO.**

IF YOU RESPOND IMMEDIATELY, YOU WILL ASSURE EARLY REINSTATEMENT OF COVERAGE AND MINIMIZE CLAIM DELAY.

Direct Billing Enrollment Information — Must Be Completed

Applicant Section (See Reverse Side for Instructions as to Information Requested in Items 1-8 Below, and Mailing Instructions)

1. Applicant's Name (Last, First, Middle Initial)	2. Applicant's Social Security Number	3. Employee's Social Security Number (If Applicant is Other than Terminated Employee)
4. Applicant's Date of Birth *(MM/DD/YYYY)*	5. Applicant's Address (Street, City, State, ZIP Code)	6. Telephone Number

7. Coverage is for:

☐ **Medical Single**
- ☐ Self Only
- ☐ Spouse Only
- ☐ Child Only

☐ **Medical Family**
- ☐ Self & Spouse
- ☐ Self & Child/Children
- ☐ Spouse & Child/Children
- ☐ Self, Spouse & Child/Children

☐ **FSA**

If you or any of your dependents are covered under another Group Health Plan, please indicate Type of Coverage, Health Plan Sponsor and Family Members Covered.

_____
_____
_____

8.	Name (First, Middle Initial, Last)	Social Security Number	Rel. Code*	Birth Date MM / DD /YYYY
Employee			**Self**	**/ /**
Dependent				**/ /**
Dependent				**/ /**
Dependent				**/ /**
Dependent				**/ /**

* *Relationship Codes: Husband (H); Wife (W); Son (S); Daughter (D); Sponsored Male Child (Y); Sponsored Female Child (X)*

A check to cover the number of months from the date of Group Insurance Termination should accompany this enrollment.

Applicant's Signature (Required)	Date

If you make the monthly payment(s) as indicated, your group health coverage will be continued for up to:

- 18 months following termination of employee's employment or lost eligibility due to reduction in hours.
- 18 months following the date of the employee's divorce, legal separation, or dependent child's ineligibility.
- 36 months of coverage for eligible dependants following the death of an employee.
- 36 months following cessation of employment due to disability.
- The date on which the DOD NAF HBP ceases to provide any employee health coverage. (However, if health coverage is replaced, further continuation will be provided under the terms of any succeeding arrangement.)
- **The date following your termination date on which you are or become covered under another group health plan or enrolled in Medicare.**

Applicant's Instructions for Completion of Direct Billing Enrollment Information

To be completed **by the former employee** if block 1 or 5 is checked; **by the spouse** if block 2 or 3 is checked; and **by the former dependent child** if block 4 is checked.

Item No. 1 Please complete your name: (Last, First & Middle Initial).

Item No. 2 Fill in your Social Security Number.

Item No. 3 Fill in the Social Security Number of the employee who originally held the coverage under the group. This should be completed for all applicants other than the terminated employee.

Item No. 4 Your Date of Birth.

Item No. 5 Complete your full address.

Item No. 6 Fill in a telephone number where you can be contacted.

Item No. 7 Check off either block to advise of any dependent coverage information. Enrollment coverages will be the same for all family members unless a separate request form is furnished.

Item No. 8 List applicant's eligible dependents to be covered under this application.

The Names, Relationship and Date of Birth of all eligible dependents should be listed. These dependents must have been previously covered under the group at the time of the TCC Qualifying Event.

Sign and date the form. Retain a copy for your files and send the original, along with a check* for the coverage period to date, to:

Aetna
Individual Billing Administration
Temporary Continuation of Coverage Unit
PO Box 14391
Lexington, KY 40512-4391

***REMINDER: THE CHECK FOR THIS INITIAL PAYMENT MUST COVER THE NUMBER OF FULL MONTHS FROM THE INSURANCE TERMINATION DATE TO THE TIME OF YOUR ELECTION.**

Participant's Ongoing Responsibilities

- Remit monthly premiums to the Direct Billing Unit by the due date.
- Submit claims in the normal fashion to the Claim Benefit Payment Office.
- Notify Direct Billing Unit of Changes in dependent status (provide proof).
- Notify Direct Billing Unit of Name and Address Changes.
- Report acquisition of any other group health coverage.