

CSI INSURANCE PLAN AND TRUST FUND

APPLICATION/WAIVER FORM
CONTINUATION OF COVERAGE

School Name

WAIVER OF RIGHT TO CONTINUATION OF GROUP HEALTH COVERAGE

I hereby waive the right to continue health coverage under the group benefit plan of the above-named company for myself and my dependents, if any.

Date Completed By: Signature of Employee or Qualified Beneficiary (Do not type or print)

APPLICATION FOR CONTINUATION OF GROUP HEALTH COVERAGE

(Please print or type)

The applicant may be the employee or a dependent Complete the following for the individual(s) to be covered.

1. Applicant's Name: Last First Mi 2. SS No.

3. Address: Zip

4. Sex: M F 5. Birthdate: Mo. Day Yr. 6. Event: Mo. Day Yr.

7. STATUS OF APPLICANT

a. If employee, check applicable status: Part-time Terminated Single Married Divorced Retired
b. If dependent, check applicable status: Widow Ex-Spouse Dep. Child

8. Name of covered employee

9. Please check the type of coverage you desire: Self Self and Dependents

If dependent coverage is desired, complete items 10, 11, 12, and 13. Only dependents previously covered (or those who are now eligible) and listed below are eligible for continuing coverage.

10. Dependent's Name (First & Last) 11. Birthdate 12. Relationship 13. Soc. Sec. No.
a. b. c. d. e.

14. Coverage applying for: Medical Dental

15. I hereby request continuation of the group coverage indicated above and agree to make timely payment of any required coverage charges.

Date Completed By: Applicant's Signature (Do not type or print)