



**The MEARIE Group Employee Benefit
Program REQUEST FOR BENEFIT
CONTINUATION FORM (Severance)**

THE MEARIE GROUP USE ONLY

Insurer

Policy No.

SECTION 1: Plan Member Information	
Employer Name	
Division Number	Class Number
Plan Member ID	Payroll ID (if applicable)
Plan Member Name	
FIRST NAME	
LAST NAME	
Date of Hire (MM/DD/YYYY)	Last Day Worked/Paid (MM/DD/YYYY)
ESA End Date (MM/DD/YYYY)	Is the Member disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 2: Benefit Continuation Request			
Please indicate ONLY those benefits to be continued, the amount of benefit (if applicable) and the last date of coverage. For member terminations, the following benefits CANNOT be continued beyond the ESA period: Long-Term Disability, Short-Term Disability, Supplementary/Optional Life, Life Waiver of Premium and Out-of-Country/Travel Assistance.			
BENEFIT	BENEFIT AMOUNT		LAST DAY OF COVERAGE REQUESTED (MM/DD/YYYY)
<input type="checkbox"/> Basic Term Life insurance			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Basic Life Insurance			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Supplemental and Optional Life Insurance			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> AD&D Insurance			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Long-Term Disability			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Short-Term Disability			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Health	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Dental	<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Employee Assistance Program (EAP)			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Best Doctors			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Healthcare Spending Account			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Critical Illness			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:
<input type="checkbox"/> Other (Please specify)			<input type="checkbox"/> ESA End Date <input type="checkbox"/> Other:

SECTION 3: Plan Administrator Authorization (no signature required)	
<input type="checkbox"/>	As the plan administrator, I authorize The MEARIE Group to process the changes noted above.
Plan Administrator Name (Signature)	
Date (MM/DD/YYYY)	

The Plan Administrator is responsible for the following:

1. Obtaining legal advice regarding termination of employment and continuation of benefits including ESA legislation, if applicable,
2. Collecting any required plan member premium contributions for the benefits to be continued, as applicable,
3. Advising The MEARIE Group if, subsequent to the approval of continuation of benefits, coverage should cease earlier than requested; and,
4. Informing the plan member of the terms and conditions under which coverage is being continued.