CIGNA Health and Life Insurance Company (CHLIC)
Hospital Supplemental Continuation Request Form

Insured individuals and their currently covered eligible dependents may elect to continue their Group Hospital Supplemental coverage from the date employment terminates. Coverage may continue until you are eligible for Medicare. The individual who elects to continue coverage is required to pay the full monthly premium on the first of each month. Failure to do so will result in the termination of the continuation provision. PLEASE NOTE: Termination Notices are NOT sent. REMITTING THE PREMIUM IS THE EMPLOYEE'S SOLE RESPONSIBILITY; THERE IS NO DIRECT COMPANY BILLING. If you will be receiving a retirement check from the State you may elect to have your monthly premium deducted from your check. Please contact CHLIC at 800.888.5256 for the Payroll Deduction Authorization Form and additional information.

I elect to continue the following coverage:
(Premiums for the entire year are based on your age as of January 1st)

	Employee Only	**Employee & Family**
1. 30/20	( ) $__________	( ) $__________
2. PPP	( ) $__________	( ) $__________
3. SIS	( ) $__________	( ) $__________

FOR OFFICE USE ONLY:

Dept Code ____________

App #________________

Old Plan ______________

Credit________________

Check #_______________

Received______________

Check Amt_____________

Premium______________

Paid to Date____________

Effective_______________

______________________________ **Retired Employee's Name** ________________ **Date of Birth**

______________________________ **Spouse's Name** ________________ **Date of Birth**

______________________________ **Dependent's Name** ________________ **Date of Birth**

______________________________ **Dependent's Name** ________________ **Date of Birth**

Mailing Address: ____
Street or P.O. Box Number

____
City **State** **Zip**

Phone Number: ( ) ____________________ **Monthly Premium Rate: $**________________

Social Security No.: ____________________ **Date Employment Terminated:** _____/_____/_____

Date Form Completed: ____________________ **Signature:** ____________________________

PLEASE RETURN THIS FORM AND YOUR FIRST CHECK TO: CHLIC
P.O. Box 40926
Jacksonville, Fl 32203-0926