**VOLUNTARY HOSPITALS**
**HOUSE STAFF BENEFITS PLAN**
**520 EIGHTH AVENUE, SUITE 1200**
**NEW YORK, NY 10018-4181**

**Tel: (212)-356-8180** **Fax: (212)-356 – 8181** **Email: benefits@cirseiu.org** **Website: www.cirseiu.org**

June 2016

Due to Termination of Employment (the "Qualifying Event"), your Plan coverage will terminate as of June 30, 2016.

This notice contains important information about your right to continue your health care coverage in the Voluntary Hospitals House Staff Benefits Plan (VHHSBP). Please read the information contained in this notice very carefully.

Under the regulations of COBRA, however, you are now eligible to continue your insurance coverage under our self-pay program. If you elect for coverage, your insurance will become effective on July 1, 2016 and will remain in effect for a maximum of 18 consecutive months until December 31, 2017 provided you continue to pay all the monthly premiums.

Each person (Qualified Beneficiaries) in the category(ies) listed below is entitled to elect COBRA Continuation Coverage, which will continue group health care coverage under the plan:

- Employee or Former Employee
- Spouse or Former Spouse
- Dependent Child(ren) Covered under the Plan on the day before the event that caused the loss of coverage.
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan.
- **DOMESTIC PARTNERS ARE NOT COVERED UNDER COBRA.**

You will have 60 days from the later of the date of this notice or the date on which you lose (or would lose) your coverage as a result of your Qualifying Event to elect COBRA Continuation Coverage. If you do not elect coverage prior to the date upon which your coverage is currently scheduled to terminate, your coverage will be terminated as of that date. Thereafter, upon election of coverage and payment, as set forth below, your coverage will be reinstated retroactively to the date that your coverage was terminated. The available benefit packages and corresponding monthly premium rates are shown on the following pages. Please note that the BENEFIT PACKAGES DO NOT INCLUDE the Plan's Life Insurance, Accidental Dismemberment, CIRLS, Supplemental Short-Term Disability or Long-Term Disability.

To elect COBRA Continuation Coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA Continuation Coverage, your coverage under the Plan will terminate on the last day of the month in which you last worked.

You, your spouse, and dependent children may have other coverage options through the Health Insurance Marketplace, Medicaid, the Children's Health Insurance Program, and/or other group health plan coverage options (such as a spouse's plan) through what is called "special enrollment period." Some of these options may cost less and you could be eligible for a tax credit. Being eligible for COBRA Continuation Coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. You can learn more about many of these options, and the time limits for enrollment, at healthcare.gov. For instance, you have 60 days from the time you lose your job-based coverage to enroll in the Marketplace, but after 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. The special enrollment right may also be available to you, your spouse, and dependent children if you continue COBRA for the maximum time available to you.

Note that if you sign up for Marketplace coverage instead of COBRA Continuation Coverage, you cannot switch to COBRA Continuation Coverage later. If you terminate your COBRA Continuation Coverage early without another Qualifying Event, you may have to wait to enroll in Marketplace coverage until the next open enrollment period.

**Based on your present insurance coverage, you are eligible for the following COBRA plan at the following monthly premium rates:**

| BENEFIT PACKAGE | INDIVIDUAL | FAMILY |
|---|---|---|
| Managed Dental Guard (MDG) | $469.84 | $1,136.00 |

If you elect to change your plan because your current dental plan does not offer providers in your area or there is a change in your family status the following plan and rates are available as well.

| | INDIVIDUAL | FAMILY |
|---|---|---|
| Dental Guard Preferred (DGP) | $475.11 | $1,143.99 |

If you wish to continue your health coverage, you must complete and sign the attached ELECTION FORM, and return it to our office no later than August 30, 2016. If mailed, note that this form must be postmarked on or before the date set forth immediately above. If you do not elect COBRA and pay for coverage prior the date your coverage is currently scheduled to terminate, your coverage will be terminated as of that date. Thereafter, upon election of coverage and payment, as set forth below, your coverage will be reinstated retroactively to the date that your coverage was terminated. For your convenience, you should include the first month payment with the election form. However, if you do not submit payment at the time of election of coverage, you will have 45 days from the date that you elect coverage (the date the Election Form is submitted) to submit payment in full for the first month of COBRA Continuation Coverage. Your coverage will not be continued until payment is received and will terminate as scheduled. When payment is received in full, coverage will be reinstated retroactively to the date that your coverage terminated or was scheduled to terminate. Note that if mailed, payment must be postmarked within 45 days from the date of election of coverage. If payment is not received or postmarked on or before the last day of the 45-day period, you will no longer be eligible for COBRA Continuation Coverage and you will have no possibility of reinstatement of your benefits. All checks or money orders should be made payable to Voluntary Hospitals House Staff Benefits Plan (VHHSBP) or you can now pay by credit or debit card as well. (American Express and Discover are **not** accepted.)

Should you have any questions regarding COBRA coverage, please contact the Benefits Plan Office.

Sincerely,

Board of Trustees

**COBRA CONTINUATION COVERAGE ELECTION FORM**

**Instructions: To elect COBRA Continuation Coverage, complete this Election Form and return it to us. Please refer to the enclosed document entitled "Important Additional Information About Your COBRA Continuation Rights" before completing this form. Under Federal law, you have 60 days after the later of the date of this notice or the date on which you lose (or would lose) your coverage as a result of your Qualifying Event (the event that caused the loss of coverage under the Voluntary Hospitals House Staff Benefits Plan) to decide whether you want to elect COBRA continuation coverage under the Plan. See the date set forth below.**

**Send completed Election Form to: Voluntary Hospitals House Staff Benefits Plan**
**520 Eighth Avenue, Suite 1200**
**New York, NY 10018**
**(E) benefits@cirseiu.org**
**(F) (212) 356-8181**

- **This Election Form must be completed and returned by mail, email or by fax at (212) 356-8181. If mailed, it must be post-marked no later than August 30, 2016.**
- **If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA Continuation Coverage.**
- **Read the important information about your rights included in the pages after the Election Form.**

I (We) elect COBRA Continuation Coverage in the House Staff Benefits Plan (the "Plan") as indicated below. (Check one premium rate only):

**Based on your present insurance coverage, you are eligible for the following COBRA Continuation Coverage:**

| | **INDIVIDUAL** | **FAMILY** |
|---|---|---|
| ( ) **Managed Dental Guard (MDG)** | $469.84 | $1,136.00 |
| ( ) **Dental Guard Preferred (DGP)** | $475.11 | $1,143.99 |

You should be aware that the price of COBRA Continuation Coverage is likely to change annually.

Name Date of Birth Relationship to Employee SSN

a. _____

b. _____

c. _____

d. _____

**[ ]** I enclose $_____ in payment of my first monthly premium, plus, if applicable, any previous months owed. (If I have not included a check or money order(s) with this Election Form or elected to pay by credit or debit card below, payment must be sent within 45 days in order to be timely. If payment is not received or postmarked within 45 days of the date of this form, I will no longer be eligible for COBRA Continuation Coverage. The Benefits Plan Office will not send me monthly bills. Payments of the premiums each month will be solely my responsibility. I understand that if I do not submit payment for the

first month of coverage with this form or elect to pay by credit or debit card below, my coverage will not be continued until timely payment is received and will terminate as scheduled. I understand that upon the Plan's receipt of payment (within 45 days), my coverage will be reinstated retroactively to the date my coverage terminated or was scheduled to terminate.

After the initial COBRA payment, I further understand that subsequent monthly premium payments are due on or before the first day of the month of coverage to which it applies. There is a 30-day grace period to make monthly periodic payments. If payment is not received on or before the first day of the month, my coverage will be terminated as of the end of the period for which the last premium payment was remitted. If I thereafter make a monthly periodic payment in full later than the first day of the month to which it applies but before the end of the 30-day grace period (the first 30 days of that month), my coverage will be reinstated retroactively to the first day of that month. If any monthly premium payment is not received or postmarked within 30 days of the first day of the month to which it applies, I will automatically cease to be covered as of the end of the period for which the last premium payment was remitted and will have no right to reinstatement of my benefits.

**[ ]** I have filled out the Credit Card Authorization Form included in this notice, and authorize the Plan to deduct my first monthly premium, and any premiums thereafter, according to the information provided on my application.

Member Signature: _____ Date: _____

# COBRA HEALTH BENEFITS - CREDIT CARD AUTHORIZATION FORM

Payments to the Voluntary Hospitals House Staff Benefits Plan ("VHHSBP" or the "Plan") for COBRA Continuation Coverage may be made by check, money orders, credit or debit card. If you want to pay your monthly COBRA premiums by credit or debit card, complete this authorization form and mail or fax it to the Benefits Plan Office at the address above. ***The Plan will not process your credit card authorization if you have not already submitted a COBRA Continuation Coverage Election Form to the Benefits Plan Office.***

**COBRA APPLICANT INFORMATION** Social Security Number: |__|__|__|-|__|__|-|__|__|__|__|

Last Name: _____ First Name: _____

**Payment by Credit or Debit Card**

- Premiums for COBRA continuation coverage are due on the 1st day of each month.
- If you choose to pay by credit, or debit card, your card will be charged within 5 business days after receipt of this letter for all outstanding premiums and current premiums.
- All subsequent monthly premiums will be charged on the 28th calendar day of the month immediately prior to the benefit period.

**For example**, if your employment ended on October 31, 2014, you may be eligible for COBRA Continuation Coverage beginning on November 1, 2014. If the Plan receives the original completed and signed Credit Card Authorization Form on December 15th, your credit or debit card will be charged on or before December 22nd (5 business days) for the November and December premiums, and for all other premiums that are due and owing.

**The Plan will continue to charge the monthly premiums to your credit or debit card on the 28th day of each month until you cancel your COBRA Continuation Coverage, you are no longer eligible for COBRA Continuation Coverage, or until the Plan receives written notice from you to discontinue the credit or debit card charge authorization.**

Monthly premium rates for COBRA coverage are likely to change annually on July 1st. You will be notified of any change to the monthly premium rate prior to the effective date.

**Discontinue Future Charges**

To discontinue future charges to your credit or debit card, the Plan must receive written notification from you at least ten (10) business days prior to the 1st of the month for which you intend to cease payment.

Credit Card (check one) Visa MasterCard

**Cardholder's Name (exactly as it appears on card):**

First Name: _____ Last Name:_____

Credit Card Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Card Expiration Date (Month/Year) ____/_____

Cardholder Billing Address: _____

City: _____ State: _____ Zip: _____

Cardholder Contact Number (if different from COBRA participant's Billing Phone Number): _____

**CREDIT CARD AUTHORIZATION**

- I authorize the Plan to charge my credit or debit card for the monthly COBRA Continuation Coverage premiums in the amount of $_____ per month.

- I understand that upon receipt of this authorization, the Plan will charge my card for the first monthly premium and any other monthly premiums and underpayments that are due.
- I also understand that the Plan will charge my credit or debit card on the 28th day of each month thereafter until my COBRA Continuation Coverage terminates or I provide written notification to the Plan.

I understand that the monthly premium rate for COBRA Continuation Coverage is likely to change annually on July 1st. I also authorize the Plan to adjust the monthly charge to my credit or debit card to reflect any change to the monthly premium rate.

Cardholder Signature: _____ Date: _____

**Credit or debit card payment cannot be processed without the cardholder's signature.**

**FOR INTERNAL USE ONLY**

First Deduction: $_____ (Total outstanding amount plus current month's fee)

Reoccurring Monthly Rate: $ _____

COBRA expiration date: _____

Total months left on COBRA:_____

Unique ID: _____

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# IMPORTANT ADDITIONAL INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

**What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families opportunity to continue their health care coverage when there is a "Qualifying Event" that would result in a loss of coverage under an employer's plan. Depending on the type of Qualifying Event, "Qualified Beneficiaries" may include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. More detailed information concerning who is a Qualified Beneficiary is contained in the COBRA section of your summary plan description.

COBRA Continuation Coverage is the same coverage that the Plan gives to other participants or beneficiaries under the plan who are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA Continuation Coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan including open enrollment and special enrollment rights.

**How long will COBRA Continuation Coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may continue only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for a spouse and dependents who are Qualified Beneficiaries for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date the employee became eligible for Medicare. This notice shows the maximum period of COBRA Continuation Coverage available to the Qualified Beneficiaries.

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time, (see page titled "When and how must payment for COBRA Continuation Coverage be made?").
- a Qualified Beneficiary becomes covered, after electing COBRA Continuation Coverage, under another group health plan.
- a covered employee becomes entitled to Medicare benefits (Under Part A, Part B, or both) after electing COBRA Continuation Coverage, or
- the Plan ceases to provide any group health coverage.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving COBRA Continuation Coverage (such as fraud). In addition, COBRA Continuation Coverage may be terminated earlier if the employer that employed you prior to your Qualifying Event has stopped contributing to this Plan, but is making group health coverage available through another health plan.

**How can you extend the length of COBRA Continuation Coverage?**

If you elect COBRA Continuation Coverage, an extension of the maximum period of coverage may be available if a Qualified Beneficiary is disabled or a Second Qualifying Event occurs. You must notify the Plan Office of a disability or a Second Qualifying Event in order to extend the period of COBRA Continuation Coverage. **Failure to provide timely notice of a disability or Second Qualifying Event, as described below, may affect the right to extend the period of COBRA Continuation Coverage.**

**Disability Before Termination**

An 11-month extension of coverage may be available if any of the Qualified Beneficiaries is determined by the Social Security Administration ("SSA") to be disabled within the meaning of Title II or Title XVI of the Social Security Act. The disability has to have started at some time prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage.

Written notice must be sent within **60 days of the later of** (1) the date on which the SSA issues the disability determination; (2) the date on which the Qualifying Event occurs; or (3) the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event. You must also provide a copy of the SSA Determination along with your notice.

You must also provide the Plan Office with a notice of an SSA determination if you are no longer disabled. That notice must be sent no later than **60 days after** the date of the determination by the SSA that you are no longer disabled.

Each Qualified Beneficiary who has elected COBRA Continuation Coverage will be entitled to the 11-month disability extension if one of them qualifies. If the Qualified Beneficiary is determined to no longer be disabled by the SSA, you must notify the Plan of that fact within 60 days after that determination.

**Second Qualifying Event**

If, during an 18-month maximum period of COBRA Continuation Coverage resulting from loss of coverage because of a Qualifying Event, you die, become divorced (or legally separated), become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 total months measured from the date of the Qualifying Event resulting in a loss of coverage or the date you first became entitled to Medicare, if that is earlier. To extend COBRA when a Second Qualifying Event occurs, you must notify the Plan Office in writing within 60 days of a Second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's right to extended COBRA coverage.

**How can you elect COBRA Continuation Coverage?**

To elect COBRA Continuation Coverage, you must complete the COBRA Continuation Coverage Election Form and furnish it according to the directions on that form. This form must be received or postmarked on or before the date set forth on the form, which is 60 days from the later of the date of the form or the date on which you lose (or would lose) your coverage as a result of your Qualifying Event. If you do not elect COBRA Continuation Coverage and pay for the first month of coverage prior the date your coverage is currently scheduled to terminate, your coverage will be terminated as of that date. Thereafter, upon election of coverage and timely payment for the first month of coverage, as set forth below in the section titled "When and how must payment for COBRA Continuation Coverage be made?", your coverage will be reinstated retroactively to the date that your coverage was terminated.

Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, the employee's spouse may elect COBRA Continuation Coverage even if the employee does not. COBRA Continuation Coverage may be elected for only one, several, or for all dependent children who are Qualified Beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the spouse of an employee who is a Qualified Beneficiary may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries and covered parents/legal guardians may elect COBRA for a minor child.

In considering whether to elect COBRA Continuation Coverage, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) after your group health coverage ends because of the Qualifying Event listed above. You can learn more about options you may have, and the time limits for enrollment, at healthcare.gov. You may also have the same special enrollment right at the end of your COBRA Continuation Coverage if you get COBRA Continuation Coverage for the maximum time available to you.

**How much does COBRA Continuation Coverage cost?**

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA Continuation Coverage.

You should be aware that the price of COBRA Continuation Coverage is likely to change when the plan's COBRA premiums are revised and updated, generally on an annual basis.

## When and how must payment for COBRA Continuation Coverage be made?

**First payment for COBRA Continuation Coverage**

- If you elect COBRA Continuation Coverage, you do not have to send any payment with the Election Form.
- However, if you do not submit payment in full for the first month of coverage at the time of election of coverage, your coverage will not be continued until payment is received and will terminate as scheduled. You will have 45 days from the date that you elect coverage (the date the Election Form is submitted or if mailed, postmarked) to submit the payment in full for the first month of coverage. When payment in full is received or postmarked within 45 days from the date of election, coverage will be reinstated retroactively to the date that your coverage was terminated or is scheduled to terminate.
- If mailed, payment must be received or postmarked on or before the last day of the 45-day period, or you will no longer be eligible for COBRA Continuation Coverage, and you will have no possibility of reinstatement of your benefits.
- Any claim you submit for benefits while your coverage is terminated may be denied and may have to be resubmitted once and if your coverage is reinstated.
- You are responsible for making sure that the amount of your first payment is correct.
- You may contact the Plan Office of the Voluntary Hospitals House Staff Benefits Plan at (212) 356-8180 to confirm the correct amount of your first payment.

**Periodic payments for COBRA Continuation Coverage**

- After you make your first payment for COBRA Continuation Coverage, you will be required to make periodic payments for each subsequent coverage period.
- The amount due for each coverage period for each Qualified Beneficiary is shown in this notice.
- The periodic payments can be made on a monthly basis.
- Payment in full for each coverage period of COBRA Continuation Coverage is due on the 1st day for that coverage period.
- If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. See the section immediately below for information about grace periods for periodic payments.
- ***The Plan will not send periodic notices of payments due for these coverage periods.***

**Grace periods for periodic payments**

- Although periodic payments are due on the first day of the month of coverage to which it applies, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment.
- During the 30-day grace period after the first day of coverage period for which no payment has been made, your COBRA Continuation Coverage will be terminated.
- If a periodic payment is received or postmarked later than the first day of the coverage period to which it applies, but before the end of the 30-day grace period for that coverage period, your coverage under the Plan will be retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received.
- Any claim you submit for benefits while your coverage is terminated may be denied and may have to be resubmitted once your coverage is reinstated. Please see your summary plan description for more information.
- If any periodic payment is not received or postmarked within the 30-day grace period, you will automatically cease to be covered as of the end of the period for which the last premium payment is remitted, and you will have no right to reinstatement of your benefits.

**If any periodic payment is not received or postmarked before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.**

**If you have not provided authorization for us to charge your credit card, your payment and all periodic payments for COBRA Continuation Coverage should be sent to:**

Voluntary Hospitals House Staff Benefits Plan
520 Eighth Avenue, Suite 1200
New York, NY 10018-4181

**For more information**
This notice does not fully describe continuation coverage or other rights under the Plan. More information about COBRA Continuation Coverage and your rights under the Plan are available in your summary plan description or from the Plan Office at (212) 356-8180, Monday – Friday, 9am – 5pm.

For more information about rights you may have under the Employee Retirement Income Security Act, including COBRA, the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

**Keep Your Plan Informed of Address Changes**
In order to protect your and your family's rights, you should keep the Plan Office informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Office.

**Prohibition against discrimination based on a health factor** Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

**Disability Insurance after Termination with InsMed**
One of the valuable benefits we provide our house staff officers is a comprehensive disability insurance program that replaces a significant portion of your house staff income and **guarantees departing house staff officers the right** to obtain permanent and portable income and loan repayment disability insurance after you complete your program without any regard to current or pre-existing health conditions.

**Portable Disability Insurance with InsMed**
This portable "own specialty" policy gives all departing house officers the opportunity to obtain coverage that can supplement the basic disability benefits that you may receive from a future employer, guarantees your right to protect future increases in income and insures your loan obligations. The main highlights of this program include the ability to apply for:

- Initial benefit from $2,500 to $7,500 per month of tax-free benefit
- Ability to defer up to **$7,500 per month** of future coverage
- Up to **$10,000* of total monthly benefit WITHOUT** any health evaluation!
- Student Loan Protection of $2,000/month (optional)
- Catastrophic Rider (optional)
- 3% Cost of Living Rider

**10% Permanent Rate Discount**

This coverage is not available to dental residents or to anyone who has previously been denied coverage by any carrier. A separate program with as much as a $5,000 monthly benefit is available to all house staff completing training, regardless of specialty and prior declinations.

Representatives of the InsMed Insurance Agency, Inc., the organization that we have selected to support this program, are prepared to work with you individually and can help you select the plan designs that best address your protection needs in your new employment.

You also can obtain information through a dedicated web site. Please click here to obtain additional information: http://insmedinsurance.com/14/CIRGI.html

You can also reach InsMed at info@insmedinsurance.com or by calling 800-214-7039.

We hope you take the time to better understand the benefits of your comprehensive long term disability program and to evaluate how options for portable coverage can provide comprehensive income protection that can be maintained throughout your career.

**NOTICE OF LIFE INSURANCE CONVERSATION**
**PRIVILEGE AND REQUEST FOR APPLICATION**

# The Guardian Life Insurance Company of America

| | | |
|---|---|---|
| **NAME OF PLAN:** Voluntary Hospitals House Staff Benefits Plan | **GROUP PLAN #:** G348566 | **Date:** July 1, 2016 |
| **ADDRESS OF PLAN:** 520 Eighth Avenue, Suite 1200, New York, NY 10018 | | |
| **LIFE INSURANCE AMOUNT: $150,000** | | |
| **NAME OF HOUSE STAFF MEMBER:** | **BIRTH DATE:** | |
| **ADDRESS OF EMPLOYEE (STREET, CITY, STATE, ZIP)** | **COUNTY** | |
| **EFFECTIVE DATE OF COVERAGE: JULY 1, 2016** | | |

**EMPLOYEE TERMINATION**
As your employment terminated on June 30, 2016, your Group Insurance has been discontinued. Under the conversion privilege contained in the Group Plan and described in your certificate booklet, you may convert your Group Life Insurance to an individual policy covering you and your qualified dependents.

**DEPENDENTS NO LONGER ELIGIBLE FOR GROUP COVERAGE**
As your coverage under the Group Plan terminated on June 30, 2016 conversion may be made to an individual policy under the following conditions:

1. an unmarried child upon attainment of the limiting age to cover himself or herself
2. a spouse upon death of insured employee to cover such spouse and dependent children
3. a spouse upon legal divorce or separation from insured employee to cover such spouse and dependent children
4. employee termination of coverage

Note to the Insured: to apply for conversion, review this form to be sure it is complete, sign and date the form I n the space indicated below and then return it to The Guardian Life Insurance Company of America.

_____ _____
Signature of Planholder Date

_____ _____
Signature of Insured Date

Please complete and submit the form by July 30, 2016 to the address below:

**The Guardian Life Insurance Company of America**
**PO Box 8012**
**Appleton, WI 54812-8012**