Maine Automobile Dealers Association Insurance Trust
P.O. Box 2667 – Augusta, Maine 04338-2667
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NOTICE OF GROUP INSURANCE CONVERSION PRIVILEGES

Your group life, group medical and/or group dental insurance terminates on the last day of the month in which your last day actually worked occurs. Under the terms of the Maine Automobile Dealers Association Insurance Trust Group Plan, an employee has the opportunity to continue and/or convert existing coverage subject to the conversion privilege contained in the Group Policy and described in the booklet. Enrolled Dependents may also have continuation options at certain Qualifying Events (see below).

Please complete the requested information below. If you are currently enrolled in the Medical, Dental, HRA or FSA plan, you will receive a COBRA packet from Group Dynamic that will provide you with COBRA continuation information.

QUALIFIED BENEFICIARY	Last Name:	First Name:
Mailing address:		Home Phone:
City:	State:	ZIP:
Date of Birth:	Gender:	SSN:

LIFE INSURANCE: ☐ I want ☐ I do not want to exercise my conversion privilege on the group life insurance.

Is termination due to total disability? ☐ Yes ☐ No
Is termination due to temporary layoff? ☐ Yes ☐ No
Is termination due to workers' compensation injury or illness? ☐ Yes ☐ No

Date of Qualifying Event: _____

Qualifying Event:
- ☐ Termination of Employment (last day actually worked: _____)
- ☐ Reduction of hours worked
- ☐ Retirement
- ☐ Death of covered employee/retiree
- ☐ Divorce/Legal Separation
- ☐ Dependent no longer eligible for coverage
- ☐ Covered employee/retiree becomes entitled to Medicare, dependents may continue identical coverage
- ☐ Other _____

Please List Benefits in which the Qualified Beneficiary is currently Enrolled:

Plan		Original Effective Date of Coverage	Coverage End Date
MEDICAL	☐ PPO-S $2,500 ☐ PPO-V $4,200		
HSA	☐ HSA-S $4,000 ☐ HSA-V $6,650		
COVERAGE LEVEL	☐ Single ☐ Employee Child(ren) ☐ Family		
DENTAL	☐ Single ☐ Employee Child(ren) ☐ Family		
FLEXIBLE SPENDING ACCOUNT: ☐ Yes ☐ No		HRA: ☐ Yes ☐ No	
VOLUNTARY VISION: : ☐ Yes ☐ No			

Please list all currently enrolled dependents whose coverage you want continued. If different mailing address, please list on back.

Last Name	First Name	Sex M/F	Social Security Number	Date of Birth	Relationship to Employee

SIGNATURE: _____ DATE: _____
(QUALIFIED BENEFICIARY'S SIGNATURE)

NAME OF DEALERSHIP: _____

AUTHORIZED SIGNATURE: _____ DATE: _____

NOTE: Please send original to M.A.D.A. Insurance Trust, provide copy to employee and retain second copy for dealership record.