Maine Automobile Dealers Association Insurance Trust
P.O. Box 2667 – Augusta, Maine 04338-2667
Phone: 623-3882 Fax: 623-2318
Email: carrian@maineautodealers.com

NOTICE OF GROUP INSURANCE CONVERSION PRIVILEGES

If you check below that you want to convert coverages for which you have been enrolled, you must also complete the appropriate benefits continuation enrollment forms which will be sent from the Trust office upon receipt of this form.

Employee Name _____ **Social Security Number**_____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Telephone _____

Last day actually worked: _____.

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**

Your group life, group major 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. Coverage will continue for up to 18 months (longer under special circumstances) or until any of the following reasons for termination occur:

a) **The employer ceases to provide a group health plan for all employees.**
b) **You cease to pay any required continuation payments.**
c) **You become eligible for coverage under another group health plan. (This does not prevent coverage from being continued until the end of any period in which pre-existing conditions are excluded or benefits for them are limited under another group health plan.)**
d) **You become entitled to Medicare benefits.**

LIFE INSURANCE:

☐ **I want**
☐ **I do not want**

} **to exercise my conversion privilege on the group life insurance.**

MAJOR MEDICAL INSURANCE:

☐ **I want**
☐ **I do not want**

} **to exercise my conversion privilege on the group major medical insurance.**

DENTAL INSURANCE:

☐ **I want**
☐ **I do not want**

} **to exercise my conversion privilege on the group dental insurance.**

SIGNATURE: _____ **DATE:** _____
(EMPLOYEE'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.