



Maine Automobile Dealers Association Insurance Trust

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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: <input type="checkbox"/> I want <input type="checkbox"/> I do not want to exercise my conversion privilege on the group life insurance.					
Is termination due to total disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is termination due to temporary layoff? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is termination due to workers' compensation injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date of Qualifying Event: _____ <input type="checkbox"/> Voluntary Termination <input type="checkbox"/> Involuntary Termination					
Qualifying Event: <input type="checkbox"/> Termination of Employment (last day actually worked: _____) <input type="checkbox"/> Reduction of hours worked <input type="checkbox"/> Retirement <input type="checkbox"/> Death of covered employee/retiree <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Dependent no longer eligible for coverage <input type="checkbox"/> Covered employee/retiree becomes entitled to Medicare, dependents may continue identical coverage <input type="checkbox"/> Other _____					
Please List Benefits in which the Qualified Beneficiary is currently Enrolled:					
Plan		Original Effective Date of Coverage		Coverage End Date	
MEDICAL	<input type="checkbox"/> PPO-S \$2,500 <input type="checkbox"/> PPO-V \$4,200				
HSA	<input type="checkbox"/> HSA-S \$4,000 <input type="checkbox"/> HSA-V \$6,000				
COVERAGE LEVEL	<input type="checkbox"/> Single <input type="checkbox"/> Employee Child(ren) <input type="checkbox"/> Family				
DENTAL	<input type="checkbox"/> Single <input type="checkbox"/> Employee Child(ren) <input type="checkbox"/> Family				
FLEXIBLE SPENDING ACCOUNT: <input type="checkbox"/> Yes <input type="checkbox"/> No		HRA: <input type="checkbox"/> Yes <input type="checkbox"/> No			
VOLUNTARY VISION: <input type="checkbox"/> Yes <input type="checkbox"/> 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.