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Executive Director

1335 H Street, Lincoln, NE 68508 Phone (402) 434-5660 FAX (402) 434-5673 www.nacone.org

APPLICATION

Name of Employee	Date of Employment Termination/Reduction in Hours
Identification Number (SSN of Employee)	Date of Notice
Street Address	(a) Last Effective Date of Employee's Group Coverage
City, State, Zip Code	(b) Total Monthly Premium Payable
Phone Number	County and Group Number

Plan Administrator: Nebraska County Insurance Trust

By Public Law 99-272, as an employee terminated or reduction of work hours from full-time employment for reasons other than gross misconduct in connection with your employment, whether voluntarily or not, you are entitled to continue your insurance coverage with Blue Cross and Blue Shield of Nebraska on a monthly renewal basis until the earliest of the following:

(1) Eighteen months from the date shown in (a) above.

(2) The date you become eligible for other group hospital, surgical or medical coverage, whether insured or self-insured, or you become entitled to Medicare.

(3) The date of expiration of the monthly period for which premiums were paid in the event of nonpayment of premium.

(4) The date you exercise your privilege provided under our Blue Cross and Blue Shield contract for conversion to an individual or family contract of your own.

(5) The date of termination of the group contract with Blue Cross and Blue Shield of Nebraska

The amount of monthly premium you are required to pay if you elect to continue coverage is shown in (b) above.

In order to elect to continue coverage, sign one copy of this form and mail it to:

Nebraska Association of County Officials
1335 H Street
Lincoln, Nebraska 68508

Within 60 days after receiving this notice. The first premium must be paid within 45 days after you decide to continue your insurance coverage. Therefore, premium payments are generally due within 30 days after the first day of each month of coverage. Premium amounts change from time to time. You will be notified of any change in the premium amount. If you fail to timely pay the initial premium or any subsequent monthly premium, your coverage will terminate.

ELECTION TO CONTINUE COVERAGE

I, the undersigned, **DO** elect to continue my insurance coverage with Nebraska County Insurance Trust through Blue Cross and Blue Shield of Nebraska in accordance with the provisions of the above notice. I understand that I am obligated to pay future month's premiums without further notice.

______________________________ ______________________________
Signature Social Security Number

I, the undersigned, **DO NOT** elect to continue my insurance coverage with Nebraska County Insurance Trust through Blue Cross and Blue Shield of Nebraska in accordance with the provisions of this notice.

______________________________ ______________________________
Signature Date

____
Social Security Number