



Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

**COBRA and State
Continuation of Group Health
Coverage for Qualified Persons**

Complete this form on all transfer cases that **currently** insure any individual(s) under the COBRA or State Continuation provisions. Note: if the continuation began **after** the effective date of your group plan with Nippon Life Insurance Company of America (Nippon Life Benefits), this form should not be used. Please refer to your Administration Guide for further instructions. Please complete one form per continued individual or family.

Group number _____ (Administrative office to complete)

1. Name of employer: _____

2. Prior carrier: _____

3. Continuee's relationship to employee: self spouse child

4. Continuee's name: _____

Home address: _____

Date of birth: _____ Social security number: _____

Phone number: _____ Sex: male female

5. Reason for Continuation: (check one)

employment termination

disability

reduction in work hours

ex-spouse of employee

surviving dependent(s) of employment

dependent of employee entitled to Medicare

dependent child's age exceeds eligibility

other (explain) _____

Are any of the persons listed for continuation currently covered under another group policy or Medicare?

yes no

6. Date continuation started with prior carrier: month _____ day _____ year _____

7. Check coverages continued under the prior carrier:

medical

dental

prescription drugs

vision

8. Benefits were continued for: (check applicable boxes)

employee

spouse

children

Dependent's name

Date of birth

Social security number

Note: COBRA continuation is not available to a domestic partner or to a domestic partner's dependent child.

9. If State Continuation is applicable; please indicate the state: _____

Signature _____ Date _____