Effective January 2019

NEW AUTOMATED PROCESS

Continuation of Health Coverage Notifications will be automatically issued by the BenefitsCONNECT enrollment system to terminating staff and mailed to the home address on file.

Elections and Payments are made directly to the Gallagher Benefit Services Billing Office.

Attached is a copy of the Notice Letter that will be mailed to your departing Staff member.

NOTE: Benefits are effective through the end of the month of separation of employment.

Please contact the Office of Human Resources with any questions.

hr@arch-no.org
504/310-8792 | 504/310-8793 | 504/310-8795
Dear <Employee Name>,

Enclosed please find a Continuation Health Insurance form. We offer continuation insurance for twelve months at the employee’s expense. Dental and vision coverage cannot be continued. We draft the premium from your checking account by the 5th of each month. The amount drafted will be the fully insured premium equivalents set by the Archdiocese. On July 1st there is a chance of an increase due to our renewal rates at annual enrollment.

If you do not respond requesting continuation, or if at any point we do not receive payment, we will discontinue the insurance at the end of that month.

If at any point within the year you wish to discontinue coverage earlier, please inform our Office in writing. If we do not have a written response within two weeks from the date of this letter, you will automatically be dropped from coverage.

At this point if you wish to continue coverage, we need your account information and voided check attached to the election form that has been provide. We will draft $000.00 from your account for the initial month of continuation[first month of election] on the 5th (or next banking day) and all subsequent months for your 12 months of continuation.

In addition, for those covered, you are entitled to convert your life insurance policy to an individual policy. Please contact Guardian Member Services at 1-800-525-4542 for more information.

Should you have any additional questions regarding the Continuation of Health Coverage please do not hesitate to give me a call at 334-605-1012.

Thank you,

Blair Barnes, Account Coordinator
334-605-1012
Blair_Barnes@ajg.com
CONTINUATION ELECTION / DECLINE FORM

I hereby acknowledge that my employer_________________________ has informed me
that I may, AT MY OWN EXPENSE, continue for a maximum of twelve (12) months my current health
insurance. I also acknowledge that if I accept this offer I will be subject to the same changes in insurance
rates and provider as active employees of the employer. I further acknowledge that the employer
IS NOT RESPONSIBLE for any part of the payments for this continued insurance.

I hereby elect to:

_____ Drop my current health insurance as described above.

_____ Continue *AT MY OWN EXPENSE my current health insurance as described.

*Payments will be deducted by automatic bank draft as explained in the attached notification letter.

NOTE: If already Medicare Eligible, Continuation is not allowed on our plan.

If applicable:

_____ I have worked for an Entity of the Archdiocese of New Orleans for more than 15 years and havenot
Reached Medicare eligibility (65 years).

Please check whether I may be eligible for RETIREE Continuation.

________________________________________
EMPLOYEE NAME

________________________________________
SIGNATURE

________________________________________
DATE

Please mail the return to:

Gallagher Benefit Services
P.O. Box 190 Selma, AL 36702

Or Email to: Blair_Barnes@ajg.com

BANK DRAFT INFORMATION

Bank Account #________________________

Bank Routing #________________________

Signature for ACH Authorization:________________________

PLEASE NOTE

If you have elected coverage and do NOT have a bank draft deduction for the initial month
of coverage, PLEASE CONTACT us IMMEDIATELY! (334) 605-1012