Diocese of Knoxville
Human Resources
Continuation of Benefits Form

Employee Name:	SS#:
Employment Location:	

I understand that my medical, dental and vision insurance benefits cease upon the date of loss of my benefits-eligible status with the Diocese of Knoxville. I also understand that there is a (18) month maximum extension of Medical benefits, in the plan I am already enrolled in, available to me and that I must pay the full cost of the premiums. ***(no extension available for dental or vision).***

- ☐ I elect to decline extension of my group medical benefits
- ☐ I elect to pay the premiums and extend my medical coverage.

Continuation of Benefit Costs Per Month		
	HDHP	PPO
Employee	$889.45	$1,093.45
Employee + 1	$1,395.42	$1,788.12
Family	$1405.62	$1,813.62

I elect to extend for____________month(s).

I will notify the Office of Human Resources if coverage is to be terminated earlier. Coverage lapses automatically for late/non-payment

Please return completed form with your first payment. When Continuation of Benefits is elected, payment must be made by the first of each month. All payments should be sent to the following address:

The Diocese of Knoxville
Office of Human Resources
805 S. Northshore Dr
Knoxville, TN 37919

Late/Non-payment will result in cancellation of group health plan benefits. Please keep a copy of this document for reference of payment mailing address.

Date of Loss of Benefit Eligibility:	
Signature of Employee:	Date: