Separation of Service

SEPARATION OF SERVICE
CONTINUATION OF COVERAGE INFORMATION

TERMINATING BENEFITS
COVERAGE TERMINATES THE END OF THE MONTH FOR WHICH PAYROLL DEDUCTIONS ARE MADE.

COBRA
BENEFITS THAT ARE COBRA ELIGIBLE ARE BENEFITS THAT ARE CONSIDERED "GROUP HEALTH PLANS". PLANS OFFERED THROUGH THE DISTRICT THAT FALL INTO THIS CATEGORY WOULD BE DENTAL, VISION, SUPPLEMENTAL MEDICAL & MEDICAL REIMBURSEMENT FLEXIBLE SPENDING ACCOUNTS.

COBRA REMITTANCE
EMPLOYEES WILL NEED TO REMIT COBRA PREMIUMS TO THE FOLLOWING ADDRESS BEGINNING THE FIRST DAY OF THE MONTH COBRA COVERAGE GOES INTO EFFECT. IF PAYMENTS ARE NOT RECEIVED WITHIN 60 DAYS OF THE DUE DATE (I.E. SEPTEMBER 1ST FOR THE MONTH OF SEPTEMBER), THEN THE INSURANCE COMPANY WILL TERMINATE THE EMPLOYEE'S COVERAGE. EMPLOYEE'S WILL NOT RECEIVE A MONTHLY BILLING AND IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO REMIT PREMIUMS IN A TIMELY MANNER.

MAKE CHECKS PAYABLE TO:	*CBG SERVICES FBO GATESVILLE ISD*
REMIT PREMIUMS TO:	*CBG SERVICES FBO GATESVILLE ISD* *PO BOX 827* *WACO, TX 76703*

PORTABILITY & CONVERSION
THERE ARE BENEFITS THAT CAN BE CONTINUED AFTER THE SEPARATION OF SERVICE OF AN EMPLOYEE THAT ARE NOT COBRA ELIGIBLE THROUGH PORTABILITY AND CONVERSION OPTIONS. THESE PLANS INCLUDE: TELEHEALTH, VOLUNTARY TERM LIFE INSURANCE, PERMANENT LIFE INSURANCE, SUPPLEMENTAL CANCER, SUPPLEMENTAL ACCIDENT & SUPPLEMENTAL CRITICAL ILLNESS.

EMPLOYEES HAVE 31 DAYS FROM WHEN BENEFITS TERMINATE TO ELECT PORTABILITY AND/OR CONVERSION FOR ALL BENEFITS.

CONTINUING TERM LIFE INSURANCE THROUGH ASSURANT EMPLOYEE BENEFITS
EMPLOYEES HAVE TWO OPTIONS TO CONTINUE THEIR TERM LIFE INSURANCE THROUGH THE DISTRICT, PORTABILITY AND GUARANTEED CONVERSION.

PORTABILITY ALLOWS EMPLOYEES TO CONTINUE THEIR CURRENT TERM LIFE PLANS AT THE CURRENT GROUP. PORTABLE COVERAGE IS NOT AVAILABLE IF AN EMPLOYEE OR DEPENDENT HAS AN INJURY OR SICKNESS WHICH HAS MATERIAL EFFECT ON LIFE EXPECTANCY. PORTABLE COVERAGE IS PROVIDED IN THE FORM OF TERM LIFE INSURANCE, WHICH DOES NOT GAIN CASH VALUE. LIFE PREMIUM RATES ARE BASED ON THE CURRENT GROUP PLAN RATES AND ON AGE AND INCREASE AUTOMATICALLY EVERY 5 YEARS (EXAMPLE: AGE 50, 55, 60 ETC..).

SEPARATION OF SERVICE
CONTINUATION OF COVERAGE INFORMATION CONTINUED…

GUARANTEED CONVERSION ALLOWS EMPLOYEES TO CONVERT THEIR CURRENT TERM LIFE INSURANCE PLAN INTO A WHOLE LIFE PLAN WITHOUT SUBMITTING ANY EVIDENCE OF INSURABILITY. EMPLOYEES WILL REMIT PREMIUMS DIRECTLY TO THE INSURANCE COMPANY

CONTINUING PERMANENT LIFE INSURANCE THROUGH TEXAS LIFE
EMPLOYEES CAN CONTINUE THEIR PERMANENT LIFE INSURANCE PLAN THROUGH TEXAS LIFE AT EXISTING PREMIUMS BY CONTACTING TEXAS LIFE DIRECT TO SET UP THEIR POLICY ON A DIRECT BILL OR BANK DRAFT**. 800.283.9233.**

CONTINUING TELEHEALTH & HEALTH ADVOCACY PLAN THROUGH ACCESS MEDICAL
EMPLOYEES CAN CONTINUE THEIR TELEHEALTH & HEALTH ADVOCAY PLAN THROUGH ACCESS MEDICAL BY ENROLLING IN COVERAGE AT **WWW.ACCESSMEDCARD.COM.**

CONTINUING SUPPLEMENTAL CANCER THROUGH AMERICAN PUBLIC LIFE
EMPLOYEES CAN CONTINUE THEIR CANCER PLAN THROUGH AMERICAN PUBLIFC LIFE AT EXISTING PREMIUMS THROUGH BY CONVERTING THEIR POLICY INTO AN INDIVIDUAL PLAN AND CONTINUING COVERAGE ON BANK DRAFT OR DIRECT BILL. CONTACT AMERICAN PUBLIC LIFE AT **800-256-8606.**

CONTINUING SUPPLEMENTAL ACCIDENT THROUGH ASSURANT EMPLOYEE BENEIFTS
EMPLOYEES CAN CONTINUE THEIR ACCIDENT PLAN THROUGH PORTABILITY AT EXISTING PREMIUMS BY CONTACTING ASSURANT EMPLOYEE BENEFITTS AT **866-909-6065**.

CONTINUING SUPPLEMENTAL CRITICAL ILLNESS THROUGH ASSURANT EMPLOYEE BENEIFTS
EMPLOYEES CAN CONTINUE THEIR CRITICAL ILLNESS PLAN THROUGH PORTABILITY AT EXISTING PREMIUMS BY CONTACTING ASSURANT EMPLOYEE BENEFITTS AT **866-909-6065**.

COBRA Notification

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

INTRODUCTION

THIS NOTICE HAS IMPORTANT INFORMATION ABOUT YOUR RIGHT TO COBRA CONTINUATION COVERAGE, WHICH IS A TEMPORARY EXTENSION OF COVERAGE UNDER THE PLAN. THIS NOTICE EXPLAINS COBRA CONTINUATION COVERAGE, WHEN IT MAY BECOME AVAILABLE TO YOU AND YOUR FAMILY, AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO GET IT. WHEN YOU BECOME ELIGIBLE FOR COBRA, YOU MAY ALSO BECOME ELIGIBLE FOR OTHER COVERAGE OPTIONS THAT MAY COST LESS THAN COBRA CONTINUATION COVERAGE.

THE RIGHT TO COBRA CONTINUATION COVERAGE WAS CREATED BY A FEDERAL LAW, THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA). COBRA CONTINUATION COVERAGE CAN BECOME AVAILABLE TO YOU AND OTHER MEMBERS OF YOUR FAMILY WHEN GROUP HEALTH COVERAGE WOULD OTHERWISE END. FOR MORE INFORMATION ABOUT YOUR RIGHTS AND OBLIGATIONS UNDER THE PLAN AND UNDER FEDERAL LAW, YOU SHOULD REVIEW THE PLAN'S SUMMARY PLAN DESCRIPTION OR CONTACT THE PLAN ADMINISTRATOR.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA CONTINUATION COVERAGE IS A CONTINUATION OF PLAN COVERAGE WHEN IT WOULD OTHERWISE END BECAUSE OF A LIFE EVENT. THIS IS ALSO CALLED A "QUALIFYING EVENT." SPECIFIC QUALIFYING EVENTS ARE LISTED LATER IN THIS NOTICE. AFTER A QUALIFYING EVENT, COBRA CONTINUATION COVERAGE MUST BE OFFERED TO EACH PERSON WHO IS A "QUALIFIED BENEFICIARY." YOU, YOUR SPOUSE, AND YOUR DEPENDENT CHILDREN COULD BECOME QUALIFIED BENEFICIARIES IF COVERAGE UNDER THE PLAN IS LOST BECAUSE OF THE QUALIFYING EVENT. UNDER THE PLAN, QUALIFIED BENEFICIARIES WHO ELECT COBRA CONTINUATION COVERAGE MUST PAY FOR COBRA CONTINUATION COVERAGE.

IF YOU'RE AN EMPLOYEE, YOU'LL BECOME A QUALIFIED BENEFICIARY IF YOU LOSE YOUR COVERAGE UNDER THE PLAN BECAUSE OF THE FOLLOWING QUALIFYING EVENTS:

- YOUR HOURS OF EMPLOYMENT ARE REDUCED, OR
- YOUR EMPLOYMENT ENDS FOR ANY REASON OTHER THAN YOUR GROSS MISCONDUCT.

IF YOU'RE THE SPOUSE OF AN EMPLOYEE, YOU'LL BECOME A QUALIFIED BENEFICIARY IF YOU LOSE YOUR COVERAGE UNDER THE PLAN BECAUSE OF THE FOLLOWING QUALIFYING EVENTS:

- YOUR SPOUSE DIES;
- YOUR SPOUSE'S HOURS OF EMPLOYMENT ARE REDUCED;
- YOUR SPOUSE'S EMPLOYMENT ENDS FOR ANY REASON OTHER THAN HIS OR HER GROSS MISCONDUCT;

- YOUR SPOUSE BECOMES ENTITLED TO MEDICARE BENEFITS (UNDER PART A, PART B, OR BOTH); OR
- YOU BECOME DIVORCED OR LEGALLY SEPARATED FROM YOUR SPOUSE.

YOUR DEPENDENT CHILDREN WILL BECOME QUALIFIED BENEFICIARIES IF THEY LOSE COVERAGE UNDER THE PLAN BECAUSE OF THE FOLLOWING QUALIFYING EVENTS:

- THE PARENT-EMPLOYEE DIES;
- THE PARENT-EMPLOYEE'S HOURS OF EMPLOYMENT ARE REDUCED;
- THE PARENT-EMPLOYEE'S EMPLOYMENT ENDS FOR ANY REASON OTHER THAN HIS OR HER GROSS MISCONDUCT;
- THE PARENT-EMPLOYEE BECOMES ENTITLED TO MEDICARE BENEFITS (PART A, PART B, OR BOTH);
- THE PARENTS BECOME DIVORCED OR LEGALLY SEPARATED; OR
- THE CHILD STOPS BEING ELIGIBLE FOR COVERAGE UNDER THE PLAN AS A "DEPENDENT CHILD."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

THE PLAN WILL OFFER COBRA CONTINUATION COVERAGE TO QUALIFIED BENEFICIARIES ONLY AFTER THE PLAN ADMINISTRATOR HAS BEEN NOTIFIED THAT A QUALIFYING EVENT HAS OCCURRED. THE EMPLOYER MUST NOTIFY THE PLAN ADMINISTRATOR OF THE FOLLOWING QUALIFYING EVENTS:

- THE END OF EMPLOYMENT OR REDUCTION OF HOURS OF EMPLOYMENT;
- DEATH OF THE EMPLOYEE;
- THE EMPLOYEE'S BECOMING ENTITLED TO MEDICARE BENEFITS (UNDER PART A, PART B, OR BOTH).

FOR ALL OTHER QUALIFYING EVENTS (DIVORCE OR LEGAL SEPARATION OF THE EMPLOYEE AND SPOUSE OR A DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD), YOU MUST NOTIFY THE PLAN ADMINISTRATOR WITHIN 60 DAYS AFTER THE QUALIFYING EVENT OCCURS. YOU MUST PROVIDE THIS NOTICE TO THE DISTRICT.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

ONCE THE PLAN ADMINISTRATOR RECEIVES NOTICE THAT A QUALIFYING EVENT HAS OCCURRED, COBRA CONTINUATION COVERAGE WILL BE OFFERED TO EACH OF THE QUALIFIED BENEFICIARIES. EACH QUALIFIED BENEFICIARY WILL HAVE AN INDEPENDENT RIGHT TO ELECT COBRA CONTINUATION COVERAGE. COVERED EMPLOYEES MAY ELECT COBRA CONTINUATION COVERAGE ON BEHALF OF THEIR SPOUSES, AND PARENTS MAY ELECT COBRA CONTINUATION COVERAGE ON BEHALF OF THEIR CHILDREN.

COBRA CONTINUATION COVERAGE IS A TEMPORARY CONTINUATION OF COVERAGE THAT GENERALLY LASTS FOR 18 MONTHS DUE TO EMPLOYMENT TERMINATION OR REDUCTION OF HOURS OF WORK. CERTAIN QUALIFYING EVENTS, OR A SECOND QUALIFYING EVENT DURING THE INITIAL PERIOD OF COVERAGE, MAY PERMIT A BENEFICIARY TO RECEIVE A MAXIMUM OF 36 MONTHS OF COVERAGE.

THERE ARE ALSO WAYS IN WHICH THIS 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE CAN BE EXTENDED:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

IF YOU OR ANYONE IN YOUR FAMILY COVERED UNDER THE PLAN IS DETERMINED BY SOCIAL SECURITY TO BE DISABLED AND YOU NOTIFY THE PLAN ADMINISTRATOR IN A TIMELY FASHION, YOU AND YOUR ENTIRE FAMILY MAY BE ENTITLED TO GET UP TO AN ADDITIONAL 11 MONTHS OF COBRA CONTINUATION COVERAGE, FOR A MAXIMUM OF 29 MONTHS. THE DISABILITY WOULD HAVE TO HAVE STARTED AT SOME TIME BEFORE THE 60TH DAY OF COBRA CONTINUATION COVERAGE AND MUST LAST AT LEAST UNTIL THE END OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE. [*ADD DESCRIPTION OF ANY ADDITIONAL PLAN PROCEDURES FOR THIS NOTICE, INCLUDING A DESCRIPTION OF ANY REQUIRED INFORMATION OR DOCUMENTATION, THE NAME OF THE APPROPRIATE PARTY TO WHOM NOTICE MUST BE SENT, AND THE TIME PERIOD FOR GIVING NOTICE.*]

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

IF YOUR FAMILY EXPERIENCES ANOTHER QUALIFYING EVENT DURING THE 18 MONTHS OF COBRA CONTINUATION COVERAGE, THE SPOUSE AND DEPENDENT CHILDREN IN YOUR FAMILY CAN GET UP TO 18 ADDITIONAL MONTHS OF COBRA CONTINUATION COVERAGE, FOR A MAXIMUM OF 36 MONTHS, IF THE PLAN IS PROPERLY NOTIFIED ABOUT THE SECOND QUALIFYING EVENT. THIS EXTENSION MAY BE AVAILABLE TO THE SPOUSE AND ANY DEPENDENT CHILDREN GETTING COBRA CONTINUATION COVERAGE IF THE EMPLOYEE OR FORMER EMPLOYEE DIES; BECOMES ENTITLED TO MEDICARE BENEFITS (UNDER PART A, PART B, OR BOTH); GETS DIVORCED OR LEGALLY SEPARATED; OR IF THE DEPENDENT CHILD STOPS BEING ELIGIBLE UNDER THE PLAN AS A DEPENDENT CHILD. THIS EXTENSION IS ONLY AVAILABLE IF THE SECOND QUALIFYING EVENT WOULD HAVE CAUSED THE SPOUSE OR DEPENDENT CHILD TO LOSE COVERAGE UNDER THE PLAN HAD THE FIRST QUALIFYING EVENT NOT OCCURRED.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

YES. INSTEAD OF ENROLLING IN COBRA CONTINUATION COVERAGE, THERE MAY BE OTHER COVERAGE OPTIONS FOR YOU AND YOUR FAMILY THROUGH THE HEALTH INSURANCE MARKETPLACE, MEDICAID, OR OTHER GROUP HEALTH PLAN COVERAGE OPTIONS (SUCH AS A

SPOUSE'S PLAN) THROUGH WHAT IS CALLED A "SPECIAL ENROLLMENT PERIOD." SOME OF THESE OPTIONS MAY COST LESS THAN COBRA CONTINUATION COVERAGE.

IF YOU HAVE QUESTIONS

QUESTIONS CONCERNING YOUR PLAN OR YOUR COBRA CONTINUATION COVERAGE RIGHTS SHOULD BE ADDRESSED TO THE CONTACT OR CONTACTS IDENTIFIED BELOW. FOR MORE INFORMATION ABOUT YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA), INCLUDING COBRA, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND OTHER LAWS AFFECTING GROUP HEALTH PLANS, CONTACT THE NEAREST REGIONAL OR DISTRICT OFFICE OF THE U.S. DEPARTMENT OF LABOR'S EMPLOYEE BENEFITS SECURITY ADMINISTRATION (EBSA) IN YOUR AREA OR VISIT WWW.DOL.GOV/EBSA.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

TO PROTECT YOUR FAMILY'S RIGHTS, LET THE PLAN ADMINISTRATOR KNOW ABOUT ANY CHANGES IN THE ADDRESSES OF FAMILY MEMBERS. YOU SHOULD ALSO KEEP A COPY, FOR YOUR RECORDS, OF ANY NOTICES YOU SEND TO THE PLAN ADMINISTRATOR.

Term Life

Notice of Portability

Notice of Portability Privilege

ASSURANT Employee Benefits®

All of your group Life insurance has been terminated as of the termination date indicated.

You are hereby notified that you may be entitled to port the terminated group Life insurance in accordance with the terms of the group policy's portability provision, summarized in your Certificate of Group Insurance. The maximum portability period is summarized in your Certificate of Group Insurance.

An application for portability and quote can be obtained by submitting this Notice of Portability Privilege form to the email address, fax or address shown below.

Your application must be completed and sent to Assurant Employee Benefits with the first full premium within 31 days after the termination date indicated.

Name _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

*Group policyholder Gatesville Independent School District

Group policy number 5473632

Termination date _____ Date of this notice _____

Original effective date _____ Life Amount terminated $ _____

Reason for termination _____

Date of birth _____ Totally disabled? ☐ Yes ☐ No

* If the group policy is self-administered or Third Party Administered, an employer signature is required to verify the above employee information.

Employer Signature _____ Title _____

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Assurant Employee Benefits PO Box 219304 Kansas City Missouri 64121
T 866.909.6065; F 816.556.7747; individualteam@assurant.com

Term Life
Conversion Notification

Notice of Conversion Privilege

ASSURANT Employee Benefits®

All or a portion of your group Life insurance has been terminated as of the termination date indicated.

You are hereby notified that you are entitled to convert the terminated group Life insurance to an individual Life insurance policy in accordance with the terms of the group policy's conversion privilege, summarized in your Certificate of Group Insurance. The individual policy will be issued, without medical examination, at a premium based upon the rate applicable to the class of risk to which you belong and your attained age on the effective date of the individual policy.

An application for conversion and quote can be obtained by *submitting* this Notice of Conversion Privilege form to the email address, fax or address shown below.

Your application must be completed and sent to Assurant Employee Benefits with the first full premium within 31 days after the termination date indicated.

Name _____

Street Address _____ City _____ State _____ Zip code _____

Phone Number _____ email address _____

* Group policyholder Gatesville Independent School District

Group policy number 5473632

Termination date _____ Date of this notice _____

Original effective date _____ Life Amount terminated $ _____

Reason for termination _____

Date of birth _____ Totally disabled? ☐ Yes ☐ No

*If the group policy is self-administered or Third Party Administered, an employer signature is required to verify the above employee information.

Employer signature _____ Title _____

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Assurant Employee Benefits PO Box 219304 Kansas City Missouri 64121
T 866.909.6065; F 816.556.7747; individualteam@assurant.com

Accident

Notice of Portability

Notice of Accident Only Portability Privilege

ASSURANT Employee Benefits®

All of your group Accident Only insurance has been terminated as of the termination date indicated.

You are hereby notified that you may be entitled to port the terminated group Accident Only insurance in accordance with the terms of the group policy's portability provision, summarized in your Certificate of Group Insurance. The maximum portability period is summarized in your Certificate of Group Insurance.

An application for portability and quote can be obtained by submitting this Notice of Portability Privilege form to the email address, fax or address shown below.

Your application must be completed and sent to Assurant Employee Benefits with the first full premium within 31 days after the termination date indicated.

Name _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

*Group Policyholder Gatesville Independent School District

Group Policy Number 5473632

Termination date _____ Date of this notice _____

Original effective date _____

Reason for termination _____

Date of birth _____

* If the group policy is self-administered or Third Party Administered, an employer signature is required to verify the above employee information

Employee Signature _____ Title _____

Products and services marketed byAssurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Assurant Employee Benefits PO Box 219304 Kansas City Missouri 64121
T 866.909.6065; F 816.556.7747; individualteam@assurant.com

Critical Illness
Notice of Portability

Notice of Critical Illness Portability Privilege

ASSURANT Employee Benefits®

All of your group Critical Illness insurance has been terminated as of the termination date indicated.

You are hereby notified that you may be entitled to port the terminated group Critical Illness insurance in accordance with the terms of the group policy's portability provision, summarized in your Certificate of Group Insurance. The maximum portability period is summarized in your Certificate of Group Insurance.

An application for portability and quote can be obtained by submitting this Notice of Portability Privilege form to the email address, fax or address shown below.

Your application must be completed and sent to Assurant Employee Benefits with the first full premium within 31 days after the termination date indicated.

Name _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email Address _____

*Group Policyholder Gatesville Independent School District

Group Policy Number 5473632

Termination date _____ Date of this notice _____

Original effective date _____ Amount terminated $ _____

Reason for termination _____

Date of birth _____

* If the group policy is self-administered or Third Party Administered, an employer signature is required to verify the above employee information.

Employee Signature _____ Title _____

Products and services marketed byAssurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Assurant Employee Benefits PO Box 219304 Kansas City Missouri 64121
T 866.909.6065; F 816.556.7747; individualteam@assurant.com