ARCHDIOCESE OF NEW ORLEANS

Gallagher

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

Date

Name
Address
City, LA zip

RE: CONTINUATION of HEALTH COVERAGE

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
Location / School / Parish

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 have not 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

ATTACH Voided Check Here

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