Election to Continue or Terminate ELCA Health Coverage

A Your Personal Information

Legal Name (First) _____ MI _____ Last _____ XXX–XX–☐☐☐☐ Social Security Number

Address _____ ☐☐☐☐☐☐☐ Member ID

City _____ State _____ ZIP Code _____

B ELCA Health Benefits Plan Coverage Election

☐ **I elect to continue ELCA health benefits for up to 18 months as indicated below:**[1]

Sign in to myPortico to view benefit details for all benefit options, continuation costs, and information on health savings account contributions (Silver+ and Bronze+ options only).

	Name	Termination of Employment Date
Me (the member)	_____	_____
My spouse /eligible same-gender partner[2]	_____	
My child(ren)	_____	
	_____	

☐ I elect the following ELCA-Primary health benefit option for all family members with ELCA-Primary benefits:

☐ Platinum+ ☐ Gold+ ☐ Silver+ ☐ Bronze+

☐ For all family members who are eligible for Medicare, I elect the following ELCA Medicare-Primary benefit option:

☐ Economy ☐ Standard ☐ Premium

Enclose a check (payable to Portico Benefit Services) with this completed form for the initial monthly contribution (plus any past-due amount) within 60 days of your termination of employment.

I agree to pay the monthly contribution for coverage for those named above, up to the date I notify Portico that I wish to terminate coverage. Coverage cannot be terminated retroactively. If this form and payment are not received within 60 days, you and your eligible family members forfeit your right to elect coverage continuation.

The total amount enclosed is $ _____.

You can set up payments to recur automatically each month or make real-time online payments. See Your Account on myPortico for more information about billing and payments.

1. Members who are taking military leave may continue ELCA health coverage for up to 24 months. Contact a service center representative at 800.352.2876 to determine your cost for continuing coverage. Enclose a check (payable to Portico Benefit Services) with this completed form for the initial monthly contribution (plus any past-due amount) within 60 days of your termination of employment.
2. An eligible same-gender partner (ESGP) is an individual who satisfies Portico Benefit Services' same-gender partnership requirements as attested to on a completed *Affidavit of Partnership* filed with Portico.

Continued on page 2

B ELCA Health Benefits Plan Coverage Election – Continued

☐ **I elect to terminate ELCA health benefits coverage as indicated below:**

	Name	Last Day of Coverage (MM/DD/YY)
Me (the member)		
My spouse/ESGP[2]		
My child(ren)		

If you are married or have an *Affidavit of Partnership* on file with Portico, your spouse's/ESGP's signature is REQUIRED to terminate coverage.

Spouse/ESGP's Signature _____ Date _____

C Signature

I agree to continue or terminate ELCA health benefits coverage as indicated on this form. If I am continuing coverage, I understand my health coverage must be uninterrupted and this completed form and payment must be returned to Portico within the 60-day period described in Section B.

Signature of Member (**Required**) _____ Date (MM/DD/YYYY) _____

Return this completed form to the Portico Service Center. Incomplete or illegible forms may be returned.

Portico Benefit Services
800 Marquette Ave., Ste. 1050
Minneapolis, MN 55402-2892

800.352.2876 / 612.333.7651
F 612.334.5399

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