STATEMENT OF LOST GROUP COVERAGE

NAMIC Welfare Benefit Plan

----Special Enrollment for Loss of Other Coverage is available to employees and/or their eligible dependent(s) who declined coverage under this plan when it was previously offered and was, at that time, covered under another group health plan or had other health insurance. A Special Enrollment period can occur if a person with other health coverage loses that coverage. Application for coverage under this Special Enrollment must be made in writing within 30 days after the date the other coverage ended.-----

Note: This provision will not apply if the person elects to continue the prior plan coverage at time of loss under state or federal continuation provisions until such time that continuation of coverage has been exhausted.

TO BE COMPLETED BY EMPLOYEE:

Employee Name:_____ SSN: _____/_____/_____

I acknowledge that the person(s) listed below declined coverage when previously offered through the NAMIC Group Insurance Trust because other coverage was in place and that coverage has now been lost:

NAME	RELATIONSHIP	GENDER	DATE OF BIRTH

Date coverage ended:_____ Reason coverage ended:_____

Name of other employer: _____ Other Insurance company:_____

I hereby certify that all statements and answers made above are true, complete and correct and shall be a part of my application for coverage. I understand that no dependent may be covered under this plan unless I am also a covered participant. I further understand that coverage for those named herein will be put in to effect and governed by the terms and provisions specified in the Group Plan.

_____ _____

Employee's Signature Date

TO BE COMPLETED BY EMPLOYER:

GROUP NAME:_____ MEMBER ID #_____

The employee whose signature appears above signed this statement in my presence. To the best of my knowledge and belief, the statements and answers made above are true and complete.

_____ _____ _____

Employer's Authorized Representative Title Date