CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate:
2. Name of group health plan:

1. Name of Participant:
2. Identification number of Participant:
3. Name of individuals to whom this certificate applies:

1. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

1. For further information, call:
2. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10:
3. Date waiting period or affiliation period (if any) began:
4. Date coverage began:
5. Date coverage ended (or if coverage has not ended, enter “continuing”:

*(Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.)*