HEALTH TRADITION
P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

Loss of Health Coverage

If you lose health insurance, you have **30 days** to apply for health insurance through Health Tradition.

1. **You** complete the **Employee Information.**
2. **Other health insurance company** completes the **Health Insurance Information.**
3. Submit this form and your health insurance enrollment form (**within 30 days** after you lost insurance).

EMPLOYEE INFORMATION

You complete this section.

Your Name:_____ Telephone No: (_____)_____

Subscriber Number:_____

Group Name:_____ Group No.:_____

Your Employment Start Date:_____/_____/_____ Telephone No.: (_____)_____

HEALTH INSURANCE INFORMATION

Former employer or health insurance company completes this section.

Name of Employer:_____

Name of Health Insurer:_____ Telephone No.: (_____)_____

Insured's Name:_____ Policy No._____

Coverage Termination Date:_____/_____/_____

Reason for Termination:_____

List all family members who were covered by the plan:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Individual Completing "Health Insurance Information" Section

Date

_____

Print Name and Title