Certificate of Group Health Plan Coverage

1. Date of certificate _____/_____/_____
2. Name of group health plan _____
3. Name of participant _____
4. Identification number of participant _____
5. Name of individual(s) to whom this certificate applies _____

   _____

   _____

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

   _____

   _____

7. For further information, call _____
8. If the individual(s) identified in line 3 and 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.
9. Date waiting period or affiliation period (if any) began _____/_____/_____
10. Date coverage began _____/_____/_____
11. Date coverage ended _____/_____/_____ or check here ☐ if coverage is continuing as of the date of this certificate.

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.