

Continuation of Coverage

Small employer attestation (certification)



1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001
www.bcbsks.com

Section 1

_____ hereby attests to Blue Cross and Blue Shield of Kansas
Employer name
that the employment of former employee/assistance eligible state continuation beneficiary
_____ was terminated involuntarily on ____/____/____.
former employee's name termination date (MM DD YYYY)

Signature of attesting representative:

Section 2

Name of attesting representative: _____

Title: _____

Date: ____/____/____
MM DD YYYY

Address: _____
Street

_____ City State Zip Code

Phone: (____) _____