Humana Military
Healthcare Services
Attn: CHCBP
500 West Main Street
P.O. Box 740072
Louisville, KY 40201-7472

HUMANA MILITARY
HEALTHCARE SERVICES
★★★★★

3/25/2014

[redacted]

RE: Termination of Benefits Notification - Unremarried Former Spouse
Policyholder ID: [redacted]

This letter is to inform you that your eligibility to participate in the Continued health Care benefit Program will expire. Participation in CHCBP is limited to thirty-six (36) months for an unremarried former spouse, and our records indicate that your eligibility will expire as of .

The regulations governing CHCBP do however allow for extended coverage beyond 36 months in certain cases. Specifically, in the case of an unremarried former spouse of a member or former member whose divorce occurred prior to the end of transitional health care coverage, the period of eligibility for participation in CHCBP is unlimited if the former spouse meets the following criteria:

(A) Has not remarried before the age of 55,

and

(B) Was enrolled in, or covered by, an approved health benefits plan under Chapter 55, Title 10, United States Code as the dependent of a retiree at any time during the 18-month period before the date of the divorce, dissolution, or annulment. (Both TRICARE and CHCBP would qualify as such a plan.)

A former spouse must also meet at least *one* of the following criteria in addition to both of the above criteria:

(C) Is receiving a portion of the retired or retainer pay of a member, or former member, or an annuity based on the retainer pay of the member; **or**

(D) Has a court order for payment of any portion of the retired or retainer pay; **or**

(E) Has a written agreement (whether voluntary or pursuant to a court order), which provides for an election by the member or former member to provide an annuity to the former spouse.

Should you meet the above criteria and wish to continue CHCBP coverage beyond 36 months, you must submit the following to our office:

1. Your signed statement of assurance that you have not remarried before the age of 55;

2. Proof that you meet criteria (B) above;

3. A copy of you final divorce decree or other authoritative evidence that you meet at least one of the requirements stated in (C) or (D) or (E) above; and

4. Your executed Renewal Notice, last page of this letter, together with a premium payment in the form of a check or money order for $1193 made payable to the **United States Treasury**.

Upon receipt and acceptance of your documentation and premium, we will issue you an ID card and a written notice confirming your continued coverage. Please note that your premiums must continue to be received in our office by the due date specified on the renewal notice to maintain your CHCBP coverage.

If you do not qualify for the extended CHCBP coverage beyond 36 months based on the regulatory criteria outlined in this letter, your CHCBP coverage will be terminated on the date specified in the first paragraph of this letter.

If you have any questions, or need assistance, please contact one of our Beneficiary Service Representatives at 1-800-444-5445. We will be glad to assist you.

Again, thank you for choosing the Continued Health Care Benefit Program.

Sincerely,

Linda Donovan

Linda Donovan
HMHS Director - Billing & Enrollment

RENEWAL NOTICE
CONTINUED HEALTH CARE BENEFIT PROGRAM

Return this page with your payment to:

Humana Military Healthcare Services
Continued Health Care Benefit Program
P.O. Box 740071
Louisville, KY 40201-7472

Sponsor Name: [redacted]

Policyholder ID: [redacted]

Mark appropriate box and sign prior to mailing

( ) Check for $1193 enclosed
Check or money order made
Payable to :
United States Treasury

( ) I do not wish to renew coverage

By signing this form, the applicant is certifying that he/she meets the criteria for continued CHCBP coverage. Federal funds are involved in this program and any false claims, statements, or comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal Law.

Signature: _____ Date: _____