COBRA

CONTINUATION OF COVERAGE APPLICATION

BlueCross BlueShield
of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East • P. O. Box 995
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(205) 988-2200

ENR-270 (Rev. 6-2013)

COBRA CONTINUATION OF COVERAGE APPLICATION

FOR OFFICE USE ONLY

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended.

EMPLOYEE INFORMATION

PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK BALL POINT PEN - PRESS FIRMLY)

*** INDICATES REQUIRED FIELDS**

○ DR. ○ MR. ○ MRS. ○ MS.

HEALTH GRP. NO. * HEALTH DIV. NO. HEALTH CONTRACT NUMBER *

DENTAL GRP. NO. * DENTAL DIV. NO. DENTAL CONTRACT NUMBER *

LAST NAME * FIRST NAME *

MAIDEN/MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER *

ADDRESS ☐ BILLING ☐ MAILING

CITY STATE ZIP

DATE OF BIRTH (MM/DD/YYYY) * PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL

/ / ( ) -

☐ MALE ☐ FEMALE

E-MAIL ADDRESS (Optional)

COBRA APPLICANT INFORMATION

(If different from above)

LAST NAME * FIRST NAME *

MAIDEN/MIDDLE NAME SUFFIX (JUNIOR, SENIOR) SOCIAL SECURITY NUMBER *

ADDRESS ☐ BILLING ☐ MAILING

CITY STATE ZIP

DATE OF BIRTH (MM/DD/YYYY) * PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL

/ / ( ) -

☐ MALE ☐ FEMALE

E-MAIL ADDRESS (Optional)

REASON I CAN CONTINUE COVERAGE

(Check one)

○ Death ○ Divorce ○ Legal Separation (when applicable)

○ No Longer An Eligible Dependent ○ Termination/Reduction in Hours

○ Employee is entitled to Medicare (when applicable)

DATE EVENT OCCURRED (MM/DD/YYYY) *

/ /

COORDINATION OF BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by any other group health insurance, please give the following information.

NAME OF CONTRACT HOLDER	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY	GROUP NUMBER

EMPLOYER'S NAME	NAME OF INSURANCE COMPANY

BLUE CROSS AND BLUE SHIELD COPY
TOP COPY

EMPLOYER COPY
MIDDLE COPY

EMPLOYEE COPY
BOTTOM COPY

MEDICARE BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by Medicare, please give the following information.

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

○ PART A (MM/DD/YYYY EFFECTIVE DATE) __ / __ / ____

○ PART B (MM/DD/YYYY EFFECTIVE DATE) __ / __ / ____

○ PART D (MM/DD/YYYY EFFECTIVE DATE) __ / __ / ____

LIST ELIGIBLE DEPENDENTS TO BE SHOWN ON THE CONTINUATION COVERAGE AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of your Group Plan.

LAST NAME

FIRST NAME *

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER * ___ - __ - ____

RELATIONSHIP ○ SPOUSE ○ OTHER ____________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) __ / __ / ____

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER ___ - __ - ____

RELATIONSHIP ○ CHILD ○ OTHER ____________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) __ / __ / ____

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER ___ - __ - ____

RELATIONSHIP ○ CHILD ○ OTHER ____________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) __ / __ / ____

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER ___ - __ - ____

RELATIONSHIP ○ CHILD ○ OTHER ____________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) __ / __ / ____

TRANSFER COVERAGE — A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

- [ ] I acknowledge that I have received and read a COBRA notice informing me of my COBRA rights.

- [ ] I understand and acknowledge that it is the Employer's obligation (and not Blue Cross') to provide me with any and all continuation coverage to which I might be entitled under COBRA or under the provisions of the Employer's group health plan implementing COBRA. I further understand and acknowledge that my COBRA benefits are provided to me under and in accordance with the provisions of Part 6 of Title I of the Employee Retirement Income Security Act of 1974. In the event of a dispute between me and Blue Cross regarding my benefits under COBRA or under this application, I understand that any administrative remedies available under the Employer's group plan must be used and exhausted by me before bringing any action against Blue Cross, notwithstanding cancellation of the Employer's coverage.

By signing below, I agree to pay to Blue Cross and Blue Shield of Alabama the monthly premium to continue the group benefits for me and my eligible dependents, if any, who are listed above. I can continue COBRA coverage for 18 months following my termination of employment or reduction in hours or 36 months if my coverage was terminated for any other event listed above. Under certain circumstances explained in the COBRA notice, if I or a member of my family is or becomes disabled during the first 60 days of COBRA coverage, the 18 month period may be extended to 29 months.

I understand the first payment is due by 45 days after I first elected COBRA. The first payment must include all premiums retroactive to the effective date of my COBRA coverage. All other payments are due within 30 days of the due date. If I fail to pay the amount due on time or if I request that my coverage be cancelled, my coverage will end and not be reinstated under any circumstances.

I understand that coverage will end for me or any of my dependents who become covered by Medicare or any other group health coverage which does not have limitations or exclusions for pre-existing conditions or which has them but they do not apply.
I will notify you in writing if I become covered by another group plan or Medicare. If I or any of my qualified dependents become disabled according to the Social Security Administration (SSA), I will notify you in writing before the end of the 18 month period and within 60 days after the later of the date of my initial qualifying date, the date on which my coverage is lost under my group health plan because of such event, or the date of the SSA disability determination.

While I continue the benefits provided by this group, these benefits are subject to all terms and conditions of the Employer's group health plan and any agreement between the Employer and Blue Cross and Blue Shield of Alabama. My benefits and/or rates will change when this Employer's benefits change, and will end if the Employer's coverage is cancelled at the same time benefits for active employees of the Employer end, regardless of whether I have continued to pay for my coverage.

I wish to continue the following coverage:

- [ ] **HEALTH ONLY**
- [ ] **HEALTH AND DENTAL**
- [ ] **DENTAL ONLY**

- [ ] *Enclosed with the application is a check or money order for the premium payment to cover the period from the effective date of my COBRA Coverage through the current coverage period.*

SIGNATURE OF APPLICANT * ______________________________

PRINT APPLICANT NAME ______________________________

APPLICANT'S SOCIAL SECURITY NUMBER *

☐☐☐ - ☐☐ - ☐☐☐☐

DATE SIGNED ______________________

TO BE COMPLETED BY EMPLOYER

I am authorized by the Employer named below to certify that the person named above is eligible under COBRA to continue group health plan coverage to be effective for a maximum of __________ (18 or 36) months. The monthly rate for the continuation coverage will be $ _________._____ per month until notified by Blue Cross and Blue Shield of Alabama under the conditions noted above.

EMPLOYER NAME

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMPLOYER PHONE NUMBER

(☐☐☐) ☐☐☐ - ☐☐☐☐

EXTENSION

☐☐☐☐

COBRA EFFECTIVE DATE (MM/DD/YYYY) *

☐☐ / ☐☐ / ☐☐☐☐

DATE OF TERMINATION/LAYOFF (MM/DD/YYYY) (If Applicable) *

☐☐ / ☐☐ / ☐☐☐☐

SIGNATURE OF AUTHORIZED REPRESENTATIVE * ______________________________

PRINTED AUTHORIZED REPRESENTATIVE NAME ______________________________

DATE SIGNED ______________________

BLUE CROSS AND BLUE SHIELD COPY
TOP COPY

EMPLOYER COPY
MIDDLE COPY

EMPLOYEE COPY
BOTTOM COPY

Important Information About Your COBRA Premiums

Blue Cross and Blue Shield of Alabama administers benefits for COBRA subscribers so long as their former employer maintains coverage by our company. This information is provided to inform you of important information as it relates to the administration of your COBRA coverage. The information is general because the COBRA law and regulations are complex. If you have a question about your eligibility for COBRA coverage, please call your group. If you have a question about payment for COBRA coverage after you are enrolled in COBRA, please call our Customer Service Department at 1 800 292-8868.

BILLING

1. Please send your payment to Blue Cross promptly. Under COBRA regulations, Blue Cross will cancel your coverage when payment is not received within 30 days of the due date which appears on your bill. The only exception to the 30 day rule is the first payment due. You will have 45 days from election of COBRA to make the first payment. The first payment must include all premiums due since the effective date of your COBRA coverage. After the first payment, you will receive monthly invoice statements showing the monthly COBRA premium amount due. If the monthly COBRA premium amount shown to be due on the invoice statement does not match the monthly COBRA premium amount you received from your group, please call our Customer Service Department at 1 800 292-8868. If your coverage is cancelled because payment has not been received within the appropriate time frame, Blue Cross will not reinstate your COBRA coverage.

2. Each year rates for your group may increase. If this happens, your COBRA rates will also increase. Depending on when Blue Cross is notified and any new benefit issues are settled to establish new rates, you may be retroactively billed the rate increase.

3. If your check is returned to Blue Cross due to insufficient funds and we do not receive payment in full within 30 days of the due date which appears on your bill, your contract will be cancelled and will not be reinstated. If your check is returned to Blue Cross due to insufficient funds after 30 days of the due date, your contract will be cancelled and will not be reinstated.

4. If your former employer's coverage is cancelled with Blue Cross, then your COBRA coverage through Blue Cross is also cancelled. Likewise, if your former employer changes coverage to another carrier then your COBRA coverage by Blue Cross will be cancelled. You will be referred to your group for information on COBRA coverage by your new carrier.

PAYMENT PROCESSING

Your health is important to us and we want to make sure you continue receiving the best coverage available. Here are four simple steps you can take to ensure continuous coverage while you are enrolled under your COBRA coverage:

1. Pay the exact amount due by the due date. Your payment is considered past due by the delinquent date.

2. If you do not receive a statement by the first of the month, please call our Customer Service Department at 1 800 292-8868 to arrange payment.

3. Always write your contract number(s) on your check.

4. If you have health and dental coverage, return both statements with a separate check for each coverage. Remember to put your contract number(s) on both checks.

CHANGES TO YOUR COBRA COVERAGE

Any eligibility changes due to your COBRA coverage will be in accordance with the guidelines established by your group and must be reported to Blue Cross promptly.

1. To change your COBRA coverage from family to individual, your spouse must write us a letter that includes his or her signature, requesting to be removed from your COBRA coverage. If your spouse is being removed from your COBRA coverage because of a divorce or legal separation, the spouse may be eligible for an extension of COBRA coverage. Please refer to the COBRA Continuation Coverage Election Notice for more information about how to qualify for an extension of COBRA coverage in this case.

2. Address changes must be reported to us immediately by phone or letter.

3. Notify us if you become covered by any other group coverage or by Medicare.

PLEASE DETACH AND RETAIN THIS PAGE