Continuation of Coverage

(COBRA or State Continuation)

BlueCross BlueShield of Kansas*
1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001
www.bcbsks.com

Section 1

Note: An Enrollment form (40-127) of group coverage must be completed and attached to this form.

Name of participant _____
Last First MI

Address of participant _____
Street or Box

_____
City State ZIP Code

Group name _____

Section 2

Insured

Do you, your spouse, or dependent have Medicare coverage? ☐ Yes ☐ No

If yes, name of person _____

Effective date for: Part A - Hospital ____/____ Part B - Doctor ____/____
MM YYYY MM YYYY

Medicare claim number (from your Medicare card) _____

Reason participant is on COBRA Continued Benefits (Terminated employee, divorce, child married, etc.)

_____

_____

Date of COBRA occurrence (Termination date, divorce granted date, etc.) ____/____/____
MM DD YYYY

Date of State Continuation occurrence ____/____/____
MM DD YYYY

Number of months participant has coverage remaining under the provisions of the law _____

COBRA expiration date ____/____/____
MM DD YYYY

State Continuation expiration date ____/____/____
MM DD YYYY

Signature

_____ Date ____/____/____
Participant MM DD YYYY

Employer verification _____ Date ____/____/____
Name MM DD YYYY

_____
Title