Anthem

THIS SECTION MUST BE COMPLETED

Employee Member Number

Health Group Number

Dental Group Number

Vision Group Number

COBRA or State Continuation of Coverage Application

Continuation of Medical/Dental benefits may be available for you and/or covered Dependents. See your employer for eligibility. To apply for continuation of Medical/Dental benefits, complete and return this form to your Employer (or previous Employer in the event of termination of employment).85

TO BE COMPLETED BY EMPLOYER ONLY

Employee Name (First, Middle Initial, Last)

Employer Name

Date of Hire ___-___-____

☐ **STATE CONTINUATION OF COVERAGE** (Applicable to employers with less than 20 employees and church and federal government groups)

☐ **COBRA** (Applicable to employer with 20 or more employees)

FOR STATE CONTINUATION OF COVERAGE OR WHEN THE EMPLOYER DOES COBRA BILLING IF YOU ELECT TO CONTINUE COVERAGE PAYMENT MUST BE SENT TO:

PAYABLE ON OR BEFORE THE _____ DAY OF EACH MONTH COMMENCING ON _____ IN ORDER TO AVOID CANCELLATION OF YOUR COVERAGE.

THE MONTHLY PREMIUM FOR COVERAGE AS ELECTED ABOVE IS $_____ FOR MEDICAL $_____ FOR VISION AND $_____ FOR DENTAL
THERE MAY BE AN ADDITIONAL 2% CHARGE ADDED FOR COBRA AND/OR UP TO 50% FOR COBRA DISABILITY BENEFICIARIES.

LAST DAY WORKED	LAST DAY OF GROUP COVERAGE	EMPLOYEE/DEPENDENT NOTIFICATION DATE
___-___-____	___-___-____	___-___-____

GROUP ADMINISTRATOR SIGNATURE | **DATE**

TO BE COMPLETED BY EMPLOYEE

DATE OF QUALIFYING EVENT ___-___-____

QUALIFYING EVENT

EVENT FOR EMPLOYEE

☐ Termination of Employment
☐ Non-medical Leave of Absence
☐ Bankruptcy of Employer
☐ Work Related Disability
☐ Non-work Related Disability
☐ Reduction in Hours
☐ Medicare Entitlement

EVENT FOR DEPENDENT

☐ Death of Covered Employee
☐ Child's Loss of Dependent Status
☐ Bankruptcy of Employer
☐ Divorce or Legal Separation
☐ Employee's Entitlement to Medicare

Based on the qualifying event(s) checked above, list below the individuals to be covered under continuation and the coverage desired.

NAME (First, Middle Initial, Last)	RELATIONSHIP	M/F	BIRTHDATE (MM/DD/YY)	PRIMARY CARE PROVIDER NAME COMPLETE FOR HMO & POS COVERAGE	PROVIDER NUMBER	COVERAGE TYPE HEALTH	DENTAL	VISION
	ELECTOR					☐Y ☐N	☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N	☐Y ☐N
						☐Y ☐N	☐Y ☐N	☐Y ☐N

MAILING ADDRESS OF PERSON MAKING ELECTION

SOCIAL SECURITY NUMBER OF PERSON MAKING ELECTION ___-___-____ | **PHONE NUMBER**

I acknowledge that I have read the front and backside of this application and certify that I agree to all matters covered therein.

SIGNATURE OF PERSON MAKING ELECTION | **DATE**

FORM NO. 94044 (REV. 4-03 Anthem Blue Cross and Blue Shield is the parent company of HMO Colorado, Inc. and HMO Nevada. Independent Licensees of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

You are hereby notified that as a terminated employee, or an employee who has lost group coverage because of a reduction in work hours, you have the right to elect to continue group coverage for yourself and your dependents, if applicable, for a maximum period of 18 months. This coverage may end sooner if you become covered under another group plan which does not contain a pre-existing condition limitation **(COBRA and State Law)**, or the employer discontinues coverage for active employees, or premium is not paid when due, or you become entitled to Medicare benefits including Medicare Disability, **(COBRA and State Law)**, or Medicaid benefits **(State Law)**, or cause exists that would result in termination of this coverage for a similarly situated active employee. The 18 months may be extended to 29 months for a terminated member if the member is determined under the Social Security Act to have been disabled any time during the first 60 days from the employee's termination or reduction in hours; however, coverage may end on the date on which the member is determined under the Social Security act to no longer be disabled **(COBRA)**.

You are hereby notified that as a legally separated or divorced spouse, or a spouse/dependent of a deceased employee, **(COBRA or State Law)** or a spouse/dependent of an employee who selected Medicare as his/her primary coverage leaving you without coverage, or a dependent who is no longer eligible under the employee's coverage, you have the right to elect to continue group coverage for a maximum period of 36 months **(COBRA)** or 18 months **(State Law).** This coverage may end sooner if you become covered under another group plan which does not contain a pre-existing condition limitation **(COBRA and State Law),** or the employer discontinues coverage for active dependents, or premium is not paid when due, or you become entitled to Medicare benefits including Medicare Disability **(COBRA and State Law),** or Medicaid benefits **(State Law)** or cause exists that would result in termination of this coverage for a similarly situated active dependent.

If group coverage is discontinued for active employees' dependents, the COBRA or State Law will also be discontinued as of the same effective date the group is discontinued. Any premiums paid beyond that date will be refunded to the member.