Print Form

COBRA Election Form
Continuation of Coverage

EFFECTIVE DATE	GROUP NO.	DEPARTMENT NO.

I: PERSONAL INFORMATION

LAST NAME (Print)	FIRST NAME (Print)	M.I.	1 ☐ MALE 2 ☐ FEMALE
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NO.	E-MAIL ADDRESS		

III: EMPLOYEE & FAMILY INFORMATION Please list below the family members that were covered under your group health plan that you wish to continu

	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SELF				
SPOUSE				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				

IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE T

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE
SPOUSE			
DEPENDENT #1 ABOVE			
DEPENDENT #2 ABOVE			
DEPENDENT #3 ABOVE			
DEPENDENT #4 ABOVE			

V.-VII. CONTINUATION OF GROUP HEALTH CARE COVERAGE

V. You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space at the end of Section VII of this form; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Blue Cross of California, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

(1) The date eligibility for COBRA continuation coverage ends, as stated under Section V, below, or

(2) The date you fail to make timely payments of your premium for COBRA Continuation coverage, or

(3) The date your employer discontinues coverage with Blue Cross of California, or

(4) The date you become entitled to Medicare on the basis of age (65 years), or the date eighteen (18) months after you become entitled to Medicare on the basis of end stage renal disease, or

(5) The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise, unless that other group health plan contains an exclusion or limitation for a pre-existing condition for which you are covered under your current coverage with Blue Cross of California. In such a case, the date on which you would lose eligibility for continuation coverage with Blue Cross of California is the date full coverage becomes available to you under the other plan, without limitations or exclusions for pre-existing conditions.

If, as of the date your employment ends or work hours are reduced, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for continuation coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage you will lose certain rights under federal law (HIPPA) to guaranteed issue individual coverage.

VI. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California or its affiliates ("Blue Cross"), their respective agents, employees, designee, or representatives, including my Blue Cross agent, or broker, any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex) of me or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of any application for coverage or of any claim for benefits.

I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits. If my coverage is under a Group Master Policy held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure of them for the purpose of administering my coverage, utilization review or financial audit.

This authorization is effective immediately and shall remain in effect for a period of (30) months, except that it shall remain effective for use in connection with any claim for benefits for as long as any Blue Cross coverage may be in effect. A photo copy of this authorization is as valid as the original, and I and my Blue Cross agent or broker, am entitled to receive a copy of this form.

I have read and understood the above provision.

Signature _____ **Date** _____

VII. NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
ARBITRATION AGREEMENT: I understand any dispute between myself (and/or any enrolled family member) and Blue Cross of California or an affiliate ("Blue Cross") must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by law suit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and BLue Cross are giving up the right to have any dispute decided in a court of law before a jury.

I have read and understood the provisions set out on this form. All information on this form is correct and true. I understand it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.
BLUE CROSS OF CALIFORNIA IS NOT YOUR COBRA ADMINISTRATOR. FOR QUESTIONS OR CONCERNS ABOUT YOUR CONTINUING COVERAGE. PLEASE CONTACT THE HEALTH PLAN ADMINISTRATOR AT YOUR PREVIOUS EMPLOYER.

Signature _____ **Date** _____

II: SELECTED COVERAGE (You must be currently covered in these benefits in order to select these)

Check the existing benefits you wish to continue

MEDICAL

- ☐ Blue Cross HMO℠ (CaliforniaCare) (indicate Medical Group/IPA# in Section III)
- ☐ Blue Cross Preferred HMO℠ (CaliforniaCare PLUS) (indicate Medical Group/IPA# in Section III)
- ☐ Blue Cross PPO℠ (Prudent Buyer) (Medical)
- ☐ Blue Cross EPO℠ (Prudent Buyer Exclusive)
- ☐ Blue Cross POS℠ (Blue Cross Plus) (indicate Medical Group/IPA# in Section III)
- ☐ BlueCard® PPO ☐ BlueCard® EPO ☐ Medicare

DENTAL

- ☐ Choice Dental (Select One of the Following)
  - ☐ Dental Net (indicate Dental Office # in Section III) ☐ Prudent Buyer
- ☐ Dental Net (indicate Dental Office # in Section III)
- ☐ Blue Cross Dental SelectHMO (indicate Dental Office # in Section III)
- ☐ Fee For Service Dental
- ☐ National Dental PPO
- ☐ Prudent Buyer Dental PPO
- ☐ PPO Dental Exclusive

COBRA coverage includes:
- ☐ Employee Only
- ☐ Employee and Dependent(s)
- ☐ Dependent(s) Only

If Applicant is not (former) employee

Employee Name _____

Employee Soc. Sec. No. _____

rage under COBRA (you can not add any family members who were not on your previous health plan without a health statement)

AGE	SOCIAL SECURITY NUMBER	If Children are over age 19, you must check the appropriate boxes below: Qualifies as IRS Dependent	Full-Time Student	TOTALLY DISABLED	MEDICAL GROUP/IPA#	Blue Cross HMO IPA Primary Care Physician Code	Is This Your Current MD?	DENTAL OFFICE #
				☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	

SECTION INCLUDING MEDICARE (if applicable)

GROUP NUMBER

MEDICARE SECTION: Are you retired? ☐ YES ☐ NO

If yes Part A ☐ YES ☐ NO
Part B ☐ YES ☐ NO

Do any of your Dependents have Medicare? ☐ YES ☐ NO

If yes for your dependent Part A ☐ YES ☐ NO
Part B ☐ YES ☐ NO

Name(s) of Medicare Dependent(s):

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB # _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare ___ ___ ___
Name _____
HIB # _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare _
Name _____

VIII. GROUP PLAN INFORMATION TO BE COMPLETED BY EMPLOYER AT THE TIME COBRA NOTICE IS PROVIDED TO APPLICANT.

Company Name _____ Group Number(s): _____

Employee: ☐ Termination of employment ☐ Reduction of employee's work hours
☐ Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees.

Family Member: ☐ Death of the employee ☐ Divorce or legal separation from employee ☐ Loss of dependent child eligibility ☐ Employee's entitlement to Medicare
☐ Benefits terminated or reduced within one year before or after retired employee's employer filing bankruptcy, if plan provides benefits for retirees.

Date of Qualifying Event	Date of Loss of Coverage	Date When Continued Coverage Ends	Date Notice Given	Applicant's initial upon receipt of notice

Signature _____ Title of plan holder representative

Telephone number

BlueCross of California

An Independent Licensee of the Blue Cross Association
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www.bluecrossca.com
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Print Form

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