

**Consolidated Omnibus Budget Reconciliation Act (COBRA)
GROUP COVERAGE CONTINUATION APPLICATION**



SECTION I – General Enrollment Information

Applicant Information (Please complete each section of this application in ink)

Your Name (first, initial, last)		Social Security Number	Blue Cross Identification No. <i>(if currently enrolled)</i>	Date of Birth (mm/dd/yy)	Age
Mailing/Billing Address (street or route)			City, State, Zip Code	County	
Your Business Phone	Your Home Phone	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee name: _____		Group number: _____			
Blue Cross enrollee number: _____		Group name: _____			
Social Security Number: _____		Group address: _____			
Date of qualifying event: _____ mm / dd / yy					
Please check appropriate box indicating qualifying event for continuation of group coverage under COBRA:					
<input type="checkbox"/> Divorce or legal separation					
<input type="checkbox"/> Death of employee					
<input type="checkbox"/> Dependent child no longer eligible (i.e., attainment of limiting age, marriage or child provides majority of his or her financial support)					
<input type="checkbox"/> Left employment – reason _____					
<input type="checkbox"/> Covered family member(s) loses continuation coverage because qualified beneficiary becomes entitled to Medicare					
<input type="checkbox"/> Other (please indicate reason) _____					

Family Member Information

List family members you wish to enroll under your membership, including **all** eligible unmarried dependent children. The employer's benefit plan will determine their eligibility. If any family members wish to enroll separately, please submit separate applications.

Family Member's Name (first, initial, last)	Social Security Number	Relationship to Applicant <i>(spouse, child, stepchild, etc.)</i>	Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)	Social Security Number		Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)	Social Security Number		Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)	Social Security Number		Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)	Social Security Number		Date of Birth (mm/dd/yy)	<input type="checkbox"/> Male <input type="checkbox"/> Female

<p>Type of Enrollment</p> <p>Health coverage (check one)</p> <p><input type="checkbox"/> Self only</p> <p><input type="checkbox"/> Self and spouse</p> <p><input type="checkbox"/> Self, spouse and children</p> <p><input type="checkbox"/> Self and one child</p> <p><input type="checkbox"/> Self and two or more children</p> <p>Dental coverage (check one if applicable)</p> <p><input type="checkbox"/> Self only</p> <p><input type="checkbox"/> Self and spouse</p> <p><input type="checkbox"/> Self, spouse and children</p> <p><input type="checkbox"/> Self and one child</p> <p><input type="checkbox"/> Self and two or more children</p>	<p>Change Request</p> <p>Change current enrollment because of the following event:</p> <p><input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Death</p> <p><input type="checkbox"/> Court order (copy of court order required)</p> <p>Other _____</p> <p>Date event occurred _____ mm / dd / yy</p>
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Please sign Section II – Statement of Understanding on reverse side of this application.

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		

3000 E. Pine Ave. • Meridian, Idaho 83642 • (208) 345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Auditor _____

Prior and/or Current Coverage Information

Is any person listed on this application now covered or has he or she been covered by any other health insurance (including Medicare or Medicaid) during any part of the 63 days (excluding any group probation period) prior to the effective date of coverage under this program? YES NO

If the other coverage has terminated, please attach a copy of your certificate of creditable coverage; this will ensure proper credit for any preexisting conditions, if applicable.

If the other coverage is still active and will remain active, please list the persons covered under that policy and their effective dates:

_____	mm / dd / yy	_____	mm / dd / yy
_____	mm / dd / yy	_____	mm / dd / yy

Name of other health insurance carrier: _____ Policy number: _____ Is this coverage for: MEDICAL DENTAL VISION

If any person listed on this application is covered by Medicare, please complete the following:

_____	_____	_____
Name	Medicare Beneficiary Number	Reason for Medicare Entitlement (age, disability or ESRD)
_____	_____	_____
Date of Medicare Entitlement	Part A mm / dd / yy	Part B mm / dd / yy

Continuation Information

I understand and agree that the continuation of my group health coverage shall immediately terminate if I fail to pay any premium when due or if the employer through which this continued group health coverage is provided ceases to provide group health coverage to its employees. Also, my group health coverage shall immediately terminate for me or any covered family member who becomes:

- covered under any other group health coverage that does **not** contain any exclusion or limitation with respect to any preexisting condition that I or any other covered family member have, or
- entitled to Medicare benefits due to age or disability.

I will immediately notify Blue Cross of Idaho or the employer through which the continued group health coverage is provided if I or any covered family member becomes covered under any other group health coverage that does **not** contain any exclusion or limitation with respect to any preexisting condition that I or any other covered family member has, or if I or any covered family member becomes entitled to Medicare benefits as a result of age or disability.

X

Applicant's Signature (also sign in Section II)

Date _____

SECTION II – Statement of Understanding (This section must be signed by all applicants)

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent, or employee of Blue Cross of Idaho can change any part of this application or waive the requirement that I answer all questions completely and accurately, nor can any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- Blue Cross of Idaho may review this application and, at its discretion, request supplemental information from me, any family member listed on this application, or any health care providers before deciding whether to approve or reject the application.
- If this application is not approved for the program applied for, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.

- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at www.bcoidaho.com.
- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- I affirm that I have reviewed all the answers given on this application and, if an independent producer or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information given by me. I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.**

X

Applicant's Signature

Date