



**BlueCross
BlueShield
of Kansas***

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

In Topeka - (785) 291-7000
In Kansas - (800) 432-0216

Web site: www.bcbsks.com

APPLICATION FOR CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

To apply for continuation of coverage, complete this form and return it to your employer.

TO BE COMPLETED BY EMPLOYER

Date of Notice ___ / ___ / ___ Date of COBRA Qualifying Event ___ / ___ / ___

Applicant named below is eligible for and is being offered COBRA coverage by our group health plan.

Plan Administrator Signature _____

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on ___ / ___ / ___ due to one of the following:

- End of employment Reduction in hours of employment Death of employee
 Divorce or legal separation Entitlement to Medicare Loss of dependent child status

Each person in the categories checked below is entitled to elect COBRA continuation coverage which will continue group coverage under the Plan for up to 18 months 36 months 29 months

- Employee or former employee Spouse or former spouse
 Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage.
 Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan.

COBRA continuation coverage will cost: single _____ empl/spouse _____ empl/child(ren) _____ family _____

Policyholder's information on previous Blue Cross and Blue Shield of Kansas coverage:

Name _____ Identification No. _____ Group ID No. _____

TO BE COMPLETED BY APPLICANT (Always complete this section)

Application Received ___ / ___ / ___ Signature of Individual Eligible For Continuation _____

SECTION I – Complete this section to enroll in Continuation of Group Health Coverage.

I want to enroll in Continuation of Group Health Coverage. Single Empl/Spouse Empl/Child(ren) Family

Are you or any other member eligible for Medicare? Yes No Medicare Number _____

If yes, see item B on reverse side.

Name _____ Medicare A eff. date ___ / ___ / ___ Medicare B eff. date ___ / ___ / ___

Applicant Name _____ Social Security No. _____
Last First MI

Address _____ Date of Birth ___ / ___ / ___ Gender Male
Street

City _____ State _____ ZIP _____ County _____ Work Phone (_____) _____
Area Code

Name of Employer _____ Home Phone (_____) _____
Area Code

List additional family members to be enrolled.

FIRST	MI	LAST	Gender	SOCIAL SECURITY NO.	RELATIONSHIP TO APPLICANT	Full Time Student? Y or N	Date of Birth Mo. Day Yr.	Place of Employment	Primary Care Physician

Name of College/Trade School _____

Signature of Applicant _____ Date ___ / ___ / ___

Important Information (more on reverse side)

First payment due 45 days from date of election, payment must bring the policy current. Monthly premiums are due by the 1st of the month in which coverage is billed. Failure to pay within 30 days of the due date will result in termination as of the paid-to-date.

SECTION II – Complete this section if you do NOT wish to enroll.

I do NOT want Continuation of Group Health Coverage for myself and/or my dependents that are eligible.

Signature of Individual Eligible for Continuation _____ Date ____ / ____ / ____

**Blue Cross and Blue Shield of Kansas
CONTINUATION RIGHTS FOR EMPLOYEES AND DEPENDENTS**

I. CONTINUATION OF HEALTH COVERAGES - COBRA

- A. Your group health plan provides the following individuals the opportunity to continue the group health coverage for up to 36 months after their coverage would otherwise terminate, subject to Item II below.
- a. Widows of covered employees (applies to covered surviving spouses and children of deceased employees).
 - b. Divorced or legally separated spouses of covered employees (applies to covered spouse and children of employees).
 - c. Covered spouses and children of Medicare eligible covered employees (the 36 months starts on the date Medicare is effective for the insured), when termination of a covered employee occurs within 18 months of the Medicare entitlement.
 - d. Covered dependent children who become ineligible under our group health plan due to age or marriage.
- B. Covered employees who lose their single or family group health coverage due to voluntary termination, strike, layoff, discharge, (other than for reason of gross misconduct) or a reduction in work hours, will have the opportunity to continue their single or family group health coverage under the group health plan for up to 18 months, subject to Item II below; employees who at the time of termination, are qualified for social security disability under the Social Security Act or become qualified within 60 days of the qualifying event, have the ability to continue group health coverage for up to 29 months.

If the disability is due to End Stage Renal Disease, group coverage is primary for 30 months. COBRA will extend the coverage until Medicare becomes the primary payer of health benefits. At that time you would be eligible for a Medicare supplement plan.

If you have Medicare Parts A and/or B for reasons other than ESRD, your Medicare coverage WILL become your primary payor with COBRA being the secondary payor. You must enroll in Medicare Part B to receive the highest level of benefits, as benefits will be carved out if you do not have Medicare Part B.

- C. During the continuation period, the continuee must pay the full monthly cost for the health coverage. The former employer is not required to absorb any part of the cost of continued health coverage.

The employer (plan administrator) must notify a terminated employee within 14 days of the termination date of the employee's right to continued coverage. Within 60 days of the termination date, the terminated individual may elect the continuation right. The terminated individual has an additional 45 days from the date of the election of continuation to pay the required premiums to Blue Cross and Blue Shield of Kansas. The premiums required is the amount to bring the policy current. No gaps in coverage will be permitted.

In the case of a divorce, legal separation or a dependent reaching the limiting age or marriage, the employee or beneficiary must notify the employer within 60 days of date of the qualifying event. The employer then must inform the beneficiary of their right to continued coverage within 14 days of receipt of the notice from the employee or beneficiary. The beneficiary then has 60 days from receipt of the notice from the employer in which to elect continued coverage.

The terminated individual who has elected to continue under the group health coverage must pay the monthly premium payment by the 1st of the month for which coverage is billed. For example, the billing for March is mailed by Blue Cross and Blue Shield the middle of February. Failure to pay by March 1st terminates the continued coverage as of the paid to date. Subject to a 30 day grace period following the paid-to-date within which one may pay premiums. If premiums are not paid within the grace period, coverage terminates as of the paid-to-date and there is no conversion privilege.

II. TERMINATION OF CONTINUATION

Your group health continuation right will terminate on the earlier of:

- A. The expiration of the 36, 29 or 18 month period described above.
- B. The date your former employer ceases to provide any group health plan to any employee.
- C. The date the individual fails to pay the applicable premium on a timely basis.
- D. The date the individual becomes covered under any other group health plan which does not limit or eliminate benefits based upon pre-existing health conditions, or becomes entitled to benefits under Medicare (in such a case, a spouse who is not eligible for Medicare may continue coverage if the family coverage is held at such a time). In addition, if the individual becomes covered under another group health plan other than by reason of employment or through coverage of a spouse to whom the individual is married at the time group health coverage would otherwise have terminated, the individual may continue the group health coverage.

III. CONVERSION PRIVILEGES

A conversion option will be extended to eligible continued individuals at the end of the continuation period. The conversion option is also available prior to the end of the continuation period to individuals who wish to drop the continued group benefits prior to its completion.

IV. CONTINUATION OF COVERAGE

If you are NOT eligible for Continuation of Benefits under COBRA, you may be eligible to continue coverage under State Continuation or converting your coverage to a Blue Cross and Blue Shield Non-Group program.

V. CHANGE OF EMPLOYER HEALTH INSURERS

If your employer changes from Blue Cross and Blue Shield to another insurance carrier, you no longer have a right to coverage under Blue Cross and Blue Shield -- your right to continue changes to the new carrier of your employer.