BlueCross BlueShield of Texas

P.O. Box 655730
Dallas, Texas 75265-5730

Continuation of Coverage Application

To: Group Accounts Department

From: Group Name_____ Group/Section No._____

Part I
Application For COBRA First Qualifying Event

Name of Subscriber:_____

Name and Social Security number of Applicant (if not Subscriber):_____; SSN _____-_____-_____

Individual number(s) under which applicant had coverage: Health _____; Dental _____

Select Coverage being applied for: ☐ Health ☐ Dental

Applicant is requesting continuation of coverage pursuant to COBRA due to the following reason (check applicable box):

1. Continued coverage for a maximum of **18** months due to employee's reduction in work hours, retirement or termination on_____.
   (Specify last work day)

   Coverage requested for:
   - ☐ Employee and all dependent(s) listed on prior group coverage
   - ☐ Employee and specific dependent(s) listed on prior group coverage
   - ☐ Employee only **(Complete Enrollment Application/Change Form to drop dependents - Required)**
   - ☐ Dependent(s) only, if listed on prior group coverage - **(Complete Enrollment Application/Change Form - Required)**

   Should a dependent with continued coverage for a maximum of **18** months experience a second qualifying event during this period, they may be eligible to extend their coverage. See the reverse side of this form for details.

2. Dependent coverage continuation for a maximum of **36** months due to the following **(Complete Enrollment Application/ Change Form - Required):**
   - ☐ Death of employee on _____.
   - ☐ Finalized date of divorce from employee on _____.
   - ☐ Dependent child ceasing to meet the dependent requirements of your group contract (e.g. age limit). Please give reason and date of loss of dependency status: _____ _____
     (Reason) (Date)
   - ☐ Employee's coverage cancelled as a result of becoming entitled to Medicare benefits on_____. Only dependent coverage to be continued.

3. ☐ Continued coverage as a result of the employer filing a Title XI bankruptcy proceeding on _____ as long as the employer continues to provide coverage for any of its employees. Applicant must have been covered as an employee, dependent, a retiree, a dependent of a retiree, or a surviving spouse of a retiree.

Are you or any member of your family covered by

A. Medicare ☐ Yes ☐ No

OR

B. Any other group Health or Dental Insurance ☐ Yes ☐ No

If the answer to A or B is Yes complete the remainder of this section

Type of Other Group Coverage ☐ Health ☐ Dental

Eff. Date of Other Coverage _____ / _____ / _____ Month Day Year

Name of Policyholder	Mo.	Day	Yr. of Birth	Relationship to Applicant
				☐ Self ☐ Spouse ☐ Child

Group/Policy Number ID Number	Name(s) of Person(s) Covered

Name and Address of Other Health Care or Dental Carrier	Phone No.	Other Group Employer's Name

I have read this Application for COBRA continuation of coverage and I certify the information stated hereon is correct. I understand that coverage under any **other group health plan** *(which does not contain any applicable exclusion or limitation with respect to any pre-existing condition) or* **entitlement to Medicare will terminate the continued coverage. I also understand this application does NOT provide any life or disability insurance coverage**.

_____

Signature of Applicant (Date)

_____

Applicant's Home Address No. and Street Name City State ZIP

See reverse side for COBRA second qualifying event or state continuation of coverage for dependents.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company★
Southwest Texas HMO, Inc.★ d/b/a HMO Blue® Texas ★Independent Licensees of the Blue Cross and Blue Shield Association

Group Name_____Group/Section No._____

Part II
Application for COBRA Second Qualifying Event

Name of Subscriber:_____

Name and Social Security number of Applicant (if not Subscriber):_____; SSN _____-_____-____

Identification number(s) under which applicant had coverage: Health _____; Dental_____

Select Coverage being applied for: ☐ Health ☐ Dental

Applicant is requesting an extension of continued coverage due to the occurrence of a second qualifying event during the 18-month period of continued coverage. If approved, the Applicant will be entitled to continued coverage for a period (which began on the effective date of the continued coverage) not to exceed **36** months. The second qualifying event was the following **(Complete Enrollment Application/ Change Form - Required):**

☐ Finalized date of divorce from employee_____.
☐ Death of former employee on _____.
☐ Dependent child ceasing to meet the dependent requirements of the group contract. Please give reason and date of loss of dependency status:_____ _____.
(Reason) (Date)
☐ Former Employee's coverage cancelled as a result of being entitled to Medicare Benefits on_____. Only dependent coverage to be continued.

Are you or any member of your family covered by A. Medicare ☐ Yes ☐ No **OR** B. Any other group Health Care Coverage or Dental Insurance **If the answer to A or B is Yes complete the remainder of this section**	Type of Other Group Coverage ☐ Health ☐ Dental ☐ Yes ☐ No Eff. Date of Other Coverage _____ / _____ / _____, Month Day Year

Name of Subscriber	Mo	Day	Yr. of Birth	Relationship to Applicant ☐ Self ☐ Spouse ☐ Child

Group/Policy Number	ID Number	Name(s) of Person(s) Covered

Name and Address of Other Health Care or Dental Coverage	Phone No.	Other Group Employer's Name

I have read this Application for COBRA continuation of coverage and I certify the information stated hereon is correct. I understand that coverage under any **other group health plan** *(which does not contain any applicable exclusion or limitation with respect to any pre-existing condition) or* **entitlement to Medicare will terminate the continued coverage. I also understand this application does NOT provide any life or disability insurance coverage**.

_____ _____
Signature of Applicant and Home Address No. and Street Name City State ZIP (Date)

Part III
State Continuation of Coverage For Dependents

Name of Applicant:_____

Certificate number under which Applicant has coverage: _____
Applicant is requesting continuation of dependent coverage for three years pursuant to Texas legislation due to the following reason (check applicable box) **(Complete Enrollment Application/Change Form - Required):**

☐ Employee retired on_____and, as a result, dependent coverage was cancelled.
☐ Employee died on _____.
☐ Finalized date of divorce from employee _____.

I have read this Application for state continuation of coverage and the information stated hereon is correct. I understand that substantially similar coverage under any other health policy or contract will terminate the continued coverage and I certify that no one applying for the continued coverage has obtained such other health coverage. I also understand this application does NOT provide any life or disability insurance coverage.

_____
Signature of Applicant and Home Address No. and Street Name City State ZIP (Date)

I certify that the applicant and dependents (if applicable) are eligible to apply for continued coverage.

_____ _____
Signature of Group Representative (Date)

This Application must be SIGNED by BOTH the APPLICANT AND THE REPRESENTATIVE of the Group or the Application will be returned.