BlueCross BlueShield of Texas

Group Administered Six (6) Month Application for State Continuation of Insurance Coverage

Who is Eligible?

You are eligible for the state continuation coverage shown if you have been continuously covered under the group coverage for at least three (3) consecutive months prior to the termination of employment, and if the loss of coverage is not due to termination of employment for cause.

Who is not Eligible?

You are not eligible for state continuation if:

1) The termination of coverage occurred because you failed to pay any required premium;
2) Any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days of the discontinuation;
3) You are or could be covered by Medicare;
4) You are covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy, hospital or medical service subscriber contract, medical practice plan, or any other prepaid plan or any other group plan or program;
5) You are eligible for similar benefits whether or not covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
6) Similar benefits are provided or available to you under the requirements of any state or federal law.

How to Apply?

The completed application and payment of the first month's premium must be submitted to your prior employer within thirty-one (31) days after the date coverage terminates.

Explanation of Your State Continuation Coverage

Continuation of coverage under the employee's health benefit plan will continue for a maximum of six (6) months. The premium will be 102% of the group premium. At the end of the six months, no other continuation options will be available.

The state continuation coverage will be effective on the day after termination of the group coverage. You will be given credit for time satisfied toward preexisting waiting periods and any charges that were applied to current deductibles and coinsurance amounts. Likewise, all amounts applied to lifetime maximums will be transferred to the state continuation coverage.

This six (6) month state continuation coverage may not terminate until the earliest of:

1) Six months after the date the employee, member, or dependent elects to continue the group coverage;
2) The date failure to make timely payments would terminate the group coverage;
3) The date the group coverage terminates in its entirety;
4) The date the insured is or could be covered under Medicare;
5) The date the insured is covered for similar benefits by another plan or program, including:
   (a) a hospital, surgical, medical, or major medical expense insurance policy;
   (b) a hospital or medical service subscriber contract; or
   (c) a medical practice or other prepayment plan;
6) The date the insured is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
7) The date similar benefits are provided or available to the insured under any state or federal law.

If you have questions regarding your rights for continuation of your health insurance, contact Blue Cross and Blue Shield of Texas toll-free at (800) 521-2227. If you have additional questions, you may contact the Texas Department of Insurance toll-free at (800) 252-3439.

Si usted tiene una pregunta sobre sus derechos bajo el proceso de continuar el seguro de salud, hable Blue Cross and Blue Shield of Texas, por el numero gratis (800) 521-2227. Si usted necesita mas informacion, se puede comunicar con el Departmento de Seguros de Tejas por el numero gratis (800) 252-3439. Se habla espanol.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

GROUP ADMINISTERED SIX MONTH APPLICATION FOR STATE CONTINUATION OF INSURANCE COVERAGE

BlueCross BlueShield of Texas

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

☐ I hereby accept State Continuation - Same Benefits (Maximum Coverage of 6 months) ***or***
☐ I hereby decline

Last Name	First		Middle Initial
Street Address	City	State	Zip Code
Sex: ☐ Male ☐ Female	Date of Birth: Mo/Day/Year / /	Social Security Number - -	Telephone Number ( ) -
Group No.	Subscriber ID Number	Coverage Cancellation Date / /	Original effective date of plan or coverage to be continued (if less than 3 consecutive months, you are not eligible) / /

Reason for Qualifying Event: ☐ Expiration of COBRA Coverage ☐ Reduction in Hours ☐ Job Termination ☐ Expiration of State Dependent Continuation ☐ Layoff ☐ Other ______

If the Employer has not selected a Managed Care Program, please disregard the Network election information.

If your Employer has selected a Managed Care Program for your group and you live outside the Network Service Area, you may elect Network Coverage. If you elect Network Coverage, your Dependents may also.
I Elect Network Coverage. ☐ Yes ☐ No

NOTE: If you do elect into the network, using non-network physician services will result in a lower reimbursement level.

For PCP selection, please complete the shaded areas below.

Important: Is any Dependent coverage required by court order? ☐ Yes ☐ No
To apply for court mandated coverage for Dependent children, contact Blue Cross and Blue Shield of Texas or visit our website at www.bcbstx.com for the appropriate form.

List Full Name of All Dependents To Be Covered ☐ Husband ☐ Wife	**Date of Birth** / /	**Social Security No.** - -	**Network Election** ☐ **Yes** ☐ **No**	**PCP**	**PCP No.**	Check Box if New Patient ☐
Complete ***ONLY*** if different from applicant's address	Street Address		City		State	ZIP
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -	**Network Election** ☐ **Yes** ☐ **No**	**PCP**	**PCP No.PCP**	Check Box if New Patient ☐
Complete ***ONLY*** if different from applicant's address	Street Address		City		State	ZIP
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -	**Network Election** ☐ **Yes** ☐ **No**	**PCP**	**PCP No.PCP**	Check Box if New Patient ☐
Complete ***ONLY*** if different from applicant's address	Street Address		City		State	ZIP
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -	**Network Election** ☐ **Yes** ☐ **No**	**PCP**	**PCP No.PCP**	Check Box if New Patient ☐
Complete ***ONLY*** if different from applicant's address	Street Address		City		State	ZIP

Are you or any member of your family entitled to be covered by any other group health, dental plan or Medicare? ☐ Yes ☐ No

If yes, please indicate what type of coverage. ☐ Health ☐ Dental ☐ Medicare

Name of Policyholder	Sex ☐ Male ☐ Female	Date of Birth Mo Day Yr / /	Relationship to Applicant	**Home OffficeOffice Use Only**
Name and Address of Other Health or Dental Plan	Company, TPA, HMO		Name of Employer	
Subscriber ID Number	Group or Policy Number	Cancel Date of Other Coverage / /	Effective Date of Other Coverage / /	Type of Policy Self ☐ Two-Person ☐ Family ☐

I understand that I am applying for coverage. I certify I have read the conversion material furnished by the Employer, and I am eligible for coverage. All information given on my Application is true and correct. I understand and agree: (1) any incorrect statements material to the eligibility for coverage shall invalidate the coverage, and (2) although I have applied for coverage listed on the Application, only those coverage(s) for which I or my Dependents are eligible will be available to me.

I understand that I have the sole obligation to pay the required premiums within thirty-one (31) days of the due date. If I fail to pay such premiums within that time, the continued coverage may be cancelled as of the last day for which premiums were paid.

I authorize any Hospital, practitioner or other health care provider to give Blue Cross and Blue Shield of Texas (BCBSTX), upon request, any information concerning the health condition of any covered person whenever BCBSTX considers such information necessary for proper disposition of a claim submitted for payment.

I understand that Blue Cross and Blue Shield of Texas' (BCBSTX) use or disclosure of individually identifiable health information whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulation under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Applicant Signature:_____ Date:_____

----------For Group Representative Use Only----------

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.