BlueCross BlueShield of Texas
P.O. Box 655730
Dallas, Texas 75265-5730

State Continuation of Coverage for Dependents Application

Employers can offer the dependents of their employee's identical health care coverage (including health, dental, drug and vision) for up to thirty-six (36) months from the loss of coverage due to divorce, death or retirement of the employee. No new additions to the continued dependent's membership are allowed except newborn children of the employee and his/her spouse. Please note, the employee is not eligible for this election.

Who is eligible?

Any dependent that was continuously covered under the employer's plan a minimum of one (1) year prior to their cancel date or the dependent is under one (1) year of age.

Cancellation of Coverage

The continued dependent remains in effect unless the dependent:

- Fails to pay the premium due
- Becomes eligible for similar coverage in another group health plan program
- No longer meets the contract definition of a child
- Requests cancellation of coverage
- Serves the full thirty-six (36) months

How to Apply?

The covered employee or qualified beneficiary is required to notify the employer or plan administrator of the qualifying event occurrence within sixty (60) days after the date of the event or the date of loss of coverage. Complete the application below, sign and return to Customer Service, P.O. Box 655730, Dallas, TX 75265-5730.

State Continuation of Coverage for Dependents Application

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) (Please Complete the 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 ____/____/_____.

_____ _____
Signature of Applicant (Date)

_____
Home Address No. and Street Name City State ZIP

I have read this Application for state continuation of coverage and the information stated herein 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.

----------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)

PLEASE NOTE
This application must be signed by BOTH the APPLICANT AND THE REPRESENTATIVE of the Group or the Application will be returned.

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