Request For Continuation Coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 (C.O.B.R.A.)

BlueCross BlueShield of Oklahoma

BlueLincs HMO℠

Mail to: Blue Cross and Blue Shield of Oklahoma • ATTN: Membership
PO Box 655924, Dallas, TX 75265-5924

PART 1 – TO BE COMPLETED BY THE EMPLOYER (PRINT IN INK OR TYPE)

Group Name	Group Number	Division Code:
Group Administrator's Signature		Today's Date

PART 2 – TO BE COMPLETED BY THE APPLICANT REQUESTING COVERAGE (EMPLOYEE, SPOUSE, CHILD)

Last Name	First Name	Middle	Social Security No.	Total Number of Persons to be Covered Under this Policy
Home Address – No. and Street Address	City	State Zip		Home Phone No.

Birth Date (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated	Relationship to Employee ☐ Self ☐ Spouse ☐ Ex-spouse ☐ Child ☐ Other	Social Security No.

Select your Coverage – Enrollee (Select One)
☐ Employee Only
☐ Employee & all dependent(s) listed on prior group coverage
☐ Employee & Specific Dependents listed on prior group coverage

Coverage - (Select One)
☐ Group Health only
☐ Group Dental only
☐ Group Health and Group Dental

Qualifying Event for Coverage for Employee: ☐ Termination of employment ☐ Reduction in number of hours worked **Date of Qualifying Event:** _____

*Coverage may continue for a period not to exceed 18 months from the date of the qualifying event.***

**A second qualifying event that takes place during this period may extend coverage to a maximum of 36 months for persons who were covered at the date of the qualifying event. Additionally, coverage extended up to 29 months for persons determined to be disabled by the Social Security Administration within the first 60 days of COBRA coverage.

Qualifying Event for Coverage for Dependent*: ☐ Death of employee ☐ Divorce or legal separation from the employee **Date of Qualifying Event:** _____

☐ Employee's entitlement to Medicare ☐ Dependent ceases to meet the group contract definition of "dependent"

*Coverage may continue for a period not to exceed 36 months from the date of the qualifying event. *Dependents are defined as children under 26 years, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors.*

**However, if one of the following events occurs, the 18, 29 or 36 month limit will not apply and coverage will end on the earliest of the following dates:
1. the date the plan sponsor ceases to provide any employee group health plan; or **2.** the last date of the grace period for which monthly premium is due; or
3. The date you become covered under another group health plan, and you have satisfied the preexisting condition exclusion provision under the new plan.

Name of Employee Coverage is Currently Under	Social Security No.

Are there any dependents that you wish to cover that are eligible for continuation? ☐ Yes ☐ No If YES, please complete Part 3 below. If NO, skip to Part 4.

PART 3 – LIST ALL CURRENTLY ENROLLED SUBSCRIBERS TO BE COVERED UNDER THIS POLICY, INCLUDING SELF (Attach second form, if necessary)

Employee or Self (First, Middle, Last)	Relationship to Employee	Birth Date (MM/DD/YYYY)	Social Security No.
Spouse (First, Middle, Last)	Relationship to Employee	Birth Date (MM/DD/YYYY)	Social Security No.
Dependent (First, Middle, Last)	Relationship to Employee	Birth Date (MM/DD/YYYY)	Social Security No.
Dependent (First, Middle, Last)	Relationship to Employee	Birth Date (MM/DD/YYYY)	Social Security No.
Dependent (First, Middle, Last)	Relationship to Employee	Birth Date (MM/DD/YYYY)	Social Security No.

PART 4 – APPLICANT SIGNATURE

Are you, or any subscriber applying for COBRA, covered by any other health insurance or medicare? ☐ Yes ☐ No
If YES, list below subscriber(s) covered along with name of insurance company.

Subscriber Name	Insurance Company	Policy Number	Subscriber Name	Insurance Company	Policy Number
Subscriber Name	Insurance Company	Policy Number	Subscriber Name	Insurance Company	Policy Number

Conversion Option: You and/or your eligible dependents may apply for conversion coverage following termination of your continuation coverage, provided you exercise your conversion privilege within 31 days of the date your coverage terminates and your employer's group contract is still in force.

I certify that all statements made on this form are complete and true to the best of my knowledge.

_____ _____

*Applicant's Signature Today's Date

* A parent or guardian MUST sign for a dependent under 18 years of age

FOR OFFICE USE ONLY

Waiver Code	Wavier Code dates - Effective & Ending