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

COBRA - Continuation of Coverage Application and Social Security Disability Extension

COBRA Qualifying Events

Who is Eligible?
Any individual who, on the day before a qualifying event, is covered under a group health plan either as the employee, the spouse of the employee, or the dependent child of the employee and loses coverage due to specific COBRA Qualifying Events. Individuals who are eligible are referred to as qualified beneficiaries. Each qualified beneficiary has a separate right to elect continuation coverage.

How Long Will COBRA Continuation Last?

Eighteen (18) months
Continuation of coverage may last up to a maximum of eighteen (18) months if the COBRA Qualifying Event is the termination of employment for any reason other than gross misconduct or due to a reduction in work hours causing loss of eligibility under the plan.

Thirty-six (36) months
Continuation of coverage for Dependents may last up to a maximum of thirty-six (36) months if the COBRA Qualifying Event is the death of the employee, divorce or separation from the covered employee, Medicare entitlement of the employee, or a child losing dependent status under the plan (such as an over age child).

Indefinite
Covered retirees, their spouses, surviving spouses and dependents of an employer, which has filed for Chapter XI bankruptcy are eligible for COBRA continuation coverage within one (1) year before **or** after the bankruptcy proceedings begin. *NOTE: The maximum coverage period for a qualified beneficiary of the retiree, which terminates upon the qualified beneficiary's death or the date that is thirty-six (36) months past the death of the retired covered employee.*

Social Security Disability Extension (if applicable)

Twenty-nine (29) months – Disability Extension Only
Continuation of coverage may last up to a maximum of twenty-nine (29) months if any of the qualified beneficiaries is determined by the Social Security Administration to be disabled. The disability must have occurred prior to the sixtieth (60^{th}) day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. Notice of the determination of disability must be provided within sixty (60) days of receipt of this notice and before the end of the eighteen (18) month period. Each qualified beneficiary who has elected continuation coverage will be entitled to the eleven (11) month disability extension if the qualified beneficiary is deemed disabled and may be charged up to 150% of the applicable cost for the additional eleven (11) months of coverage. To apply for your Social Security Disability extension, please contact Customer Service at (800) 521-2227 for further details.

COBRA Second Qualifying Events

Who is Eligible?
Any dependent of a qualified beneficiary covered under the plan at the time of the second qualifying event.

How Long Will the Second Qualifying Events for COBRA Continuation Last?

Thirty-six (36) months
A thirty-six (36)-month extension of coverage will be available to spouses and dependent children who elect continuation of coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months from the date of the second qualifying event. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee is becoming entitled to Medicare benefits under Part A and/or Part B, or a dependent child is ceasing to be eligible for coverage as a dependent under the plan. These events can be a COBRA second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the COBRA first qualifying event had not occurred. Notice of a second qualifying event must be given within sixty (60) days after the event occurs.

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Termination of COBRA coverage

A qualified beneficiary's right to COBRA continuation of coverage will be terminated when:

- Any required premium is not paid in full on time;
- The qualified beneficiary becomes covered, after election of COBRA, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary or dependent(s);
- The qualified beneficiary becomes entitled to Medicare Part A and/or Part B after electing continuation of coverage;
- The employer ceases to provide any group health plan for its employees.

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 attached application sign and return to Customer Service.

NOTICE TO GROUP ADMINISTRATOR

ALL APPLICATIONS SUBMITTED WITHOUT A SIGNATURE OF BOTH THE BENEFICIARY AND THE GROUP ADMINISTRATOR WILL BE RETURNED.

If you have questions regarding your election for COBRA coverage, contact Blue Cross and Blue Shield of Texas toll-free at (800) 521-2227. If you have additional questions regarding your COBRA rights, 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 convertir o 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.

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COBRA - Continuation of Coverage Application

To: Group Membership 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 eighteen (18) months due to employee's reduction in work hours, retirement or termination on _____ . (Specify last workday)

   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 (Please Complete the Enrollment Application/Change Form to drop dependents - Required)
   - ☐ Dependent(s) only, if listed on prior group coverage - (Please Complete the Enrollment Application/Change Form - Required)

   Should a dependent with continued coverage for a maximum of eighteen (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 thirty-six (36) months due to the following (Please Complete the 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 the 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 Plan ☐ Yes ☐ No

Type of Other Group Coverage
☐ Health ☐ Dental

Effective Date of Other Coverage
_____ / _____ / _____
Month Day Year

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

Name of Subscriber	Month Day Year 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 hereion 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.

I understand that Blue Cross and Blue Shield of Texas' 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 _____

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

See reverse sidebelow for COBRA second qualifying event.

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 eighteen (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 thirty-six (36) months. The second qualifying event was the following (Please Complete the 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 Coverage: Type of Other Group Coverage: ☐ Health ☐ Dental
Effective Date of Coverage: ____ / ____ / ____ (Month / Date / Year)

NOTE: If the answer to A or B is YES, please complete the remainder of this section below.

Name of Subscriber:	Month / Day / Year 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.

Applicant Signature Date

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

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