



Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

COBRA CONTINUATION NOTICE

(For individuals in group health plans with 20 or more employees)

Employer please note: fill out blue-lined areas before giving to employee or employee's dependent.

To _____
(Continuation Applicant)

Date of this Notice _____

Name _____
(Covered Employee)

Identification Number _____

Group health coverage for you (and your dependents, if applicable) would normally end on _____ because of the qualifying event checked below. You and/or your covered dependents, who were enrolled on the Plan immediately prior to the qualifying event, however, may be able to continue group health coverage for a limited period at your own expense, based upon the qualifying event.

Qualifying Events

- 1. The employee's termination of employment
- 2. The employee's reduction of work hours to less than those required to maintain eligibility for coverage
- 3. The employee's divorce or termination of domestic partnership
- 4. The employee's death
- 5. The employee becomes covered under Medicare
- 6. The employee's child no longer qualifies as a dependent under the eligibility terms of the Plan
- 7. For Oregon based insured plans only - The employee's spouse or domestic partner is widowed or divorced while between the ages of 55 and 65

If you become entitled to Medicare after the date of COBRA election, you will no longer be eligible for COBRA coverage. If you have other group health coverage, you may be eligible for COBRA continuation. See item #2 under Length of Continuation Coverage below.

Regence BlueCross BlueShield of Oregon will pay secondary if you are Medicare eligible. This also applies if you choose to not take Medicare coverage when you become eligible for Medicare.

Continuation Coverage

You and/or your dependents may each elect to continue health coverage separately on a self-pay basis. Covered dependents choosing to make a separate election must complete and submit a separate "Application for COBRA Continuation" within the time periods specified in this Notice.

Changes in Benefits and Premiums

If group health plan benefits change for the regular plan during the continuation period, continuation coverage will reflect the same changes. Required monthly premiums may also change during the continuation period in the manner allowed by the law. The continuation applicant will be notified by the group of any changes in benefits and/or premiums during the continuation period.

Length of Continuation Coverage

Continuation coverage begins the day after active coverage ends. Subject to all other provisions of the group's contract, the continuation period will end on the earliest of the following:

1. Premium for a continuation enrollee is not paid to the group on a timely basis; coverage will be canceled retroactive to the last day of the coverage period for which premium is paid on time.
(Premiums must be received no later than 30 days after the due date in order for continuation to remain in effect.)
2. The first day after the election that a continuation enrollee becomes covered under another group health plan, unless the other plan excludes or limits coverage for a pre-existing condition of a qualified beneficiary. The pre-existing condition must be one for which coverage is provided under the continuation coverage.

Length of Continuation Coverage, cont.

3. The day a continuation enrollee becomes covered under Medicare after the COBRA election date.
4. The day the employer stops offering the group health plan.
5. The day the Maximum Continuation Period ends. The Maximum Continuation Period is either 18, 29, or 36 months as described below from the date when continuation coverage begins:

- a) 18 months for termination of employment or reduction in hours.

If the qualifying event is termination of employment or reduction in hours and a continuation enrollee is determined by the Social Security Administration to be disabled as of the date of the qualifying event, or within the first 60 days of the continuation coverage, the 18 month continuation period may be extended for up to 11 additional months for all qualified beneficiaries.

In order to be entitled to this extension, the disabled qualified beneficiary must notify the plan administrator within 60 days of the disability determination by Social Security. The disabled qualified beneficiary's premium will increase 148% during the 19th through the 29th month of continuation coverage.

- b) Oregon based insured plans only - 36 months for spouse or domestic partner and dependents in the event of death or dissolution of marriage of the enrolled employee. If the spouse or domestic partner is between the ages of 55 and 65, continuation coverage may be extended until other group health coverage is obtained or until age 65, whichever happens first. Enrolled dependent children of the spouse or domestic partner may remain insured with the spouse or domestic partner beyond 36 months as long as they are otherwise eligible under the contract.
- c) 36 months for a covered child who ceases to be eligible as a dependent under the plan.
- d) If a second qualifying event described in (b) and (c) occurs during a continuation period described in (a), up to 36 months from the time the first continuation period began is allowed for all qualified beneficiaries. A qualified beneficiary is a covered employee or dependent that is on the plan the day prior to the qualifying event or newborns and children placed for adoption with the covered employee, and added to the plan during the period of continuation.

In order to elect the continuation coverage, each continuation applicant must do two things:

1. Complete and return the attached "Application for COBRA Continuation" to:

The applicant must apply within 60 days of the date of this notice or within 60 days of the date coverage would have normally ended, if that is later. Failure to complete and return the "Application for COBRA Continuation" within 60 days will result in the loss of the right to continuation coverage.

2. You must pay the plan administrator:
 - (a) The initial premium covering the period of time from the date that coverage would have normally ended through the end of the current month. The initial premium must be paid to the plan administrator within 45 days from the date the "Application for COBRA Continuation" is signed.

NO CLAIMS WILL BE HONORED UNTIL THE INITIAL PREMIUM IS RECEIVED BY THE PLAN ADMINISTRATOR.

- (b) Premiums are due on the _____ day of each month. Monthly premiums must be received no later than 30 days after the due date. If premiums are late, they will be returned and coverage will terminate at the end of the last month for which timely premiums were paid.

The current Monthly Premium Cost is: _____



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APPLICATION FOR COBRA CONTINUATION

Select one of the boxes below. If you are electing not to apply for continuation coverage, select the first box then, sign, date, print name clearly, include group number and/or ID number and return this form to your Plan Administrator. If you are electing to apply for continuation coverage, check the second box, complete the rest of this form and return to your Plan Administrator within the time specified in the COBRA Continuation Notice.

I choose not to apply for continuation coverage. _____ Signature _____ Date

_____ Full Name (print clearly) _____ Group Number _____ ID Number

I elect to apply for continuation of group health plan coverage due to the following Qualifying Event:

Select the appropriate box below and give date of Qualifying Event.

- 1) Employee's termination of employment _____ (Date of Qualifying Event)
- 2) Employee's reduction of work hours _____ (Date of Qualifying Event)
- 3) Divorce* _____ (Date of Qualifying Event)
- 4) Employee's death _____ (Date of Qualifying Event)
- 5) Employee becomes covered under Medicare _____ (Date of Qualifying Event)
- 6) Child(ren) no longer qualifies as dependent(s) under the eligibility terms of the plan because: _____ (Date of Qualifying Event)
- 7) For Oregon based insured plans only - The employee's spouse or domestic partner becomes widowed or divorced* while between the ages of 55 and 65 _____ (Date of Qualifying Event)

* Indicate date divorce final or termination of domestic partnership.

I understand I must notify the plan administrator at the address shown on the attached notice when I or any of my covered dependents become covered under any other group plan or covered under Medicare after my election date of COBRA. If I or any covered dependent become covered under another group health plan after COBRA election, and the other plan limits or excludes coverage for a pre-existing condition I have or a covered dependent has, that person may still be eligible for continuation coverage. Check with your plan administrator.

IN ALL INSTANCES BELOW, LIST ALL MEMBERS TO BE COVERED. Please note: Dependents may be continued only if they were covered as dependents under the group health plan on the day before the qualifying event.

Applicant's Address			City	State	ZIP Code	County
Home Phone Number ()	Work Phone Number ()	Primary Language	Marital Status <input type="checkbox"/> SGL <input type="checkbox"/> MAR <input type="checkbox"/> WID <input type="checkbox"/> DIV <input type="checkbox"/> SEP			
Applicant's Last Name	First	M.I.	Social Security Number	Birthdate (MM/DD/YY)	Sex	
Spouse or Domestic Partner's Last Name	First	M.I.	Social Security Number	Birthdate (MM/DD/YY)	Sex	
Dependent's Last Name	First	M.I.	Social Security Number	Birthdate (MM/DD/YY)	Sex	
Dependent's Last Name	First	M.I.	Social Security Number	Birthdate (MM/DD/YY)	Sex	
Dependent's Last Name	First	M.I.	Social Security Number	Birthdate (MM/DD/YY)	Sex	
Dependent's Last Name	First	M.I.	Social Security Number	Birthdate (MM/DD/YY)	Sex	

If ANY person listed above has a last name different from that of the applicant, please specify the relationship.

Is anyone above covered by MEDICARE? YES NO

If YES, please be sure to complete the MEDICARE portion of OTHER COVERAGE INFORMATION on the back of this form.

PLEASE COMPLETE AND SIGN THE REVERSE SIDE.

Dental Plan: (If applicable) Dental Plan (Fee-for-Service Plan) Choose from any licensed dentist Dentacare Select one: Willamette Dental Group (orthodontia included) Services available only through the following providers.

Dental enrollment is for: Employee Only Employee & Dependents *IF ANY DEPENDENTS ARE NOT ELECTING DENTAL COVERAGE, PLEASE LIST NAMES HERE:*

To help reduce the cost of health care, your health coverage includes a Coordination of Benefits provision in accordance with Oregon state insurance regulations or Maintenance of Benefits provision. In order for us to process your claim(s), we need the following information to determine the primary carrier as prescribed by law. We routinely investigate to update our records.

Other Coverage Information

If you or any family members listed on this application have Medicare, is coverage: PART A PART B

Member _____ Effective Date _____ Medicare Number (Please include letters) _____ Reason for Medicare Entitlement _____

Are you or any family members covered by Medicare disability? NO YES - PART A PART B

Do you or any family members, have group or individual coverage other than the coverage referenced above? If the answer to any of the above questions is "YES," please complete the section below. If you have more than one policy, please provide this information on a separate sheet.

Medical coverage? NO YES Dental coverage? NO YES Vision coverage? NO YES
 Prescription (Rx) coverage? NO YES with Orthodontia? NO YES

POLICY	Name of policyholder with other coverage	Relationship	Policyholder's Birthdate	Name of other group coverage	Phone Number ()	
	Address of other coverage			City	State	ZIP Code
	This coverage is for: <input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Numbers that identify you to other Group Plan (Group ID, Member Numbers, etc.)	
	This plan covers: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Stepchild(ren) <input type="checkbox"/> Other					
	Please list names: Name of Employer _____ <input type="checkbox"/> Continuation <input type="checkbox"/> Active <input type="checkbox"/> Retiree Effective Date _____ Termination Date _____					

Child Custody Information

When parents are divorced or legally separated, insurance regulations stipulate which health plan carrier will be primary for dependent child(ren). The carrier covering the person with custody of the child(ren) or the person who was given financial responsibility for the health expenses of the child(ren) by a court decree is primary. If you or your spouse are divorced or legally separated or your domestic partnership is terminated, please indicate who has legal custody of your child(ren) below.

Name of Child(ren)	Father	Mother	Joint*	Other	Date Awarded (*Please send copy of court decree)	Has the parent WITHOUT custody been required by court decree to provide coverage for the dependent children? YES NO If "YES," list other coverage provided
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> _____

I understand no claim(s) will be honored unless my initial premium is paid on time.

I understand that regular monthly premiums (after initial premium months), must be received no later than 30 days after the _____ day of each month for coverage to continue. I UNDERSTAND NO LATE PREMIUMS CAN BE ACCEPTED (see attached notice).

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.*

- Health information requested or disclosed may be related to treatment or services performed by:
- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
 - a clinic, hospital, long-term care or other medical facility;
 - any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
 - an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to; claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

For the protection of all of our members, knowingly providing us with false, incomplete or misleading information may result in our taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available by telephone request or on our Web site at www.or.regence.com.

_____	_____	_____	_____
Applicant's Signature	Date	Applicant's Spouse's Signature	Date
_____	_____	_____	_____
Applicant's Full Name (please print clearly)	Birthdate	Spouse's Full Name (please print clearly)	Birthdate