COBRA | COBRA Continuation Coverage Election Letter

Date of Notice:	MM/DD/YYYY	
To:	NAME OF EMPLOYEE, SPOUSE, DEPENDENT CHILDREN, AS APPROPRIATE	
Address:	ADDRESS TO WHICH NOTICE IS BEING SENT	

This notice has important information about your right to continue your healthcare coverage with your group health plan(s), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision.

To elect COBRA continuation coverage, follow the instructions to complete the Election Form (MKT-365) and submit it to the Plan Administrator at the address below. This Election Form should be included in your COBRA Election Packet (MKT-171). Federal law requires that most group health plans (including this plan) give employees and their families the opportunity to continue their healthcare coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

COBRA continuation coverage is the same coverage that the plan gives to other plan members who aren't getting continuation coverage.
Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other members covered under the plan.

If you do not elect COBRA continuation coverage, your coverage under the plan will end on	MM/DD/YYYY

Please check the reason below:

- ☐ **End of employment**
- ☐ **Reduction in hours of employment**
- ☐ **Death of employee**
- ☐ **Divorce**
- ☐ **Enrollment in Medicare**
- ☐ **Loss of dependent child status**

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group healthcare coverage under the plan for up to __________ months.

If you elect COBRA continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event within a certain time period to extend the period of COBRA continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of COBRA continuation coverage.

For more information about extending the length of COBRA continuation coverage visit www.dol.gov/ebsa/publications/cobraemployee.html.

Please check the appropriate box or boxes below and give the names:

☐ Covered employee or covered former employee		☐ Covered spouse or covered former spouse	
☐ Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage		☐ Child who is losing coverage under the plan because he or she is no longer a dependent under the plan	

If any of the persons listed above do not reside at the address to which this notice was sent, please notify the Plan Administrator of the new address for these persons so that we may give them a copy of this notice.

If elected, COBRA continuation coverage will begin on	MM/DD/YYYY	**and can last until**	MM/DD/YYYY

COBRA continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

You may elect either family coverage or single coverage for COBRA continuation coverage.

COBRA continuation coverage cost	**Family:**	**Single:**

Other coverage options may cost less. Your cost for COBRA coverage may change over time, as the cost of benefits under the plan changes.
You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in "Important Information about your COBRA Conntinuation Coverage Rights" (MKT-54).

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.
You can learn more about the Marketplace on the back of this page.

OVER ⟶

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period.You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

Premiums:	Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
Provider Networks:	If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
Drug Formularies:	If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
Severance payments:	If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
Service Areas:	Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
Other Cost-Sharing:	In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have any questions about your rights to COBRA continuation coverage, you should contact:

Plan Administrator:	Name/Position:
Address:	Phone Number:

C O B R A

Notice by Qualified Beneficiaries of Second Qualifying Event

IMPORTANT: An extension of COBRA coverage for up to 36 months (from the date of the first qualifying event) may be available to spouses and dependent children who elect COBRA if a second qualifying event occurs during the first 18 months of COBRA coverage. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. For this extension to apply, you must deliver this notice to us at:

Plan Administrator's Name	Address	City	State	Zip

within 60 days after the second qualifying event or within 60 days after the date coverage is lost under the Plan because of the event, whichever is later. **If you do not deliver this notice by the due date above, you will lose your right to an extension of COBRA continuation coverage.** Please refer to the summary plan descriptions for your group health plan(s) for more information about COBRA continuation coverage.

Group Health Plan Information:

Please check the group health plans (the "Plan") under which you have COBRA coverage: ☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP
DATE OF TERMINATION/REDUCTION IN HOURS MM/DD/YYYY			

Qualified Beneficiary Information:

Please complete the information below for each person (any spouse or dependent children) who has COBRA coverage:

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

Notice of Second Qualifying Event:

Please check the event that occurred and give the date it occurred:

	DATE OF SECOND QUALIFYING EVENT:
☐ DIVORCE OF THE EMPLOYEE AND SPOUSE* ☐ DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD ☐ DEATH OF EMPLOYEE *IF THE EVENT IS A DIVORCE, YOU MUST INCLUDE A COPY OF THE DIVORCE DECREE WITH THIS NOTICE.	MM/DD/YYYY

SIGNATURE	PRINT NAME	DATE

COBRA

Notice by Qualified Beneficiaries of SSA Disability Determination

IMPORTANT: COBRA coverage may be extended for up to 29 months (from the date of the first qualifying event) if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and must last until the end of the 18-month COBRA coverage period. You must timely deliver this notice to Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, AL 35298-0001, Fax: 205 220-6884 or 1 888 810-6884 (toll free) before the end of the 18-month period of COBRA coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage is lost under the Plan because of the initial qualifying event, or (iii) the date of the SSA disability determination. If you do not deliver this notice by the due date above, you will lose your right to an extension of COBRA continuation coverage. Please refer to the summary plan descriptions for your Plan for more information about COBRA coverage.

Group Health Plan Information: ______________________________

GROUP NAME GROUP NUMBER

Please check the group health plans (the "Plan") under which you had coverage on the day before the qualifying event:

☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP
DATE OF TERMINATION/REDUCTION IN HOURS MM/DD/YYYY			

Qualified Beneficiary Information:

Please complete the information below for each person (the employee, spouse and/or dependent children) who have COBRA coverage under the Plan:

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

Notice of SSA Disability Determination: Please complete all information below:

NAME OF DISABLED QUALIFIED BENEFICIARY	
DATE OF QUALIFIED BENEFICIARY DISABILITY MM/DD/YYYY	DATE OF SSA DISABILITY DETERMINATION MM/DD/YYYY

You must include a copy of the SSA disability determination letter with this notice.

____

SIGNATURE PRINT NAME DATE

MKT-56 (Rev. 1-2009)

C O B R A

Cobra Continuation Coverage Election Form

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: ______________________________

____

____

This Election Form must be completed and returned by mail or hand delivery on ______________________.

If mailed, it must be post-marked no later than ______________________.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date that your group health plan coverage terminated.

READ THE IMPORTANT INFORMATION PROVIDED ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS (included in COBRA Election packet MKT-171)

I (We) elect **COBRA** continuation coverage in the following group health plans (the plan) as indicated below:

Type of plans (please check): ☐ **Health** ☐ **Dental**

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

Type of coverage elected (please check one only):

☐ I (We) elect to continue family coverage under the plan
☐ I (We) elect to continue single coverage under the plan
☐ I decline/waive my right to COBRA continuation coverage under the plan

SIGNATURE PRINT NAME DATE

PRINT ADDRESS TELEPHONE NUMBER

RELATIONSHIP TO EMPLOYEE

COBRA

Important Information About Your COBRA Continuation Coverage Rights

What is COBRA continuation coverage?

A federal law known as COBRA requires that most group health plans (including the plan or plans that are listed in the COBRA Continuation Coverage Election Form and collectively referred to in this notice as "the plan") give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under the plan. Only persons known as "qualified beneficiaries" may elect to continue their coverage under the plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a qualified medical child support order is entitled to the same rights under COBRA as a dependent child of the covered employee. A child born to, adopted by or placed for adoption with a former employee during the period of COBRA coverage may also be a qualified beneficiary if the former employee is a qualified beneficiary who has elected COBRA coverage. Continuation coverage is the same coverage that the plan gives to other participants or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights and any open enrollment rights.

How long will COBRA continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce, the employee's becoming enrolled in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became enrolled in Medicare before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare enrollment or 18 months after the date of termination of employment or reduction in hours, whichever period ends last. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Can COBRA coverage terminate early?

Continuation coverage will be terminated **before** the end of the maximum period if:

- any required premium is not paid in full on time,
- after electing continuation coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, (note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusion will become prohibited beginning in 2014 under the Affordable Care Act)
- after electing continuation coverage, a qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both),
- a qualified beneficiary is covered under the additional 11-month disability extension and there has been a final determination by the Social Security Administration that the disabled qualified individual is no longer disabled, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum 18-month period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must timely notify the Plan Administrator or his designee of a disability or a second qualifying event, using the notice procedures specified below, in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage (for a maximum of 29 months of coverage) may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for this disability extension to apply, you must timely notify the Plan Administrator or its designee in writing (using the notice procedures specified below) of the SSA disability determination before the end of the 18-month period of continuation coverage **and** within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event, or (iii) the date of the SSA disability determination.

SSA Disability Notice Procedures: The SSA disability notices that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand deliver your notice to:

Blue Cross and Blue Shield of Alabama
Attention: Customer Accounts
450 Riverchase Parkway East
Birmingham, AL 35298-0001
Fax: (205) 220-6884 or 1 888 810-6884 (toll free)

Your notice must be received by Blue Cross and Blue Shield of Alabama no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event,
- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the SSA made its determination of disability.

Your notice must also include a copy of the SSA disability determination. For your convenience, we have provided a form of Notice by Qualified Beneficiaries that you may use to notify Blue Cross and Blue Shield of Alabama of a SSA disability determination. You may also get a copy of this form, at no cost to you, from either the Plan Administrator or Blue Cross and Blue Shield of Alabama. If these procedures are not followed or if the notice is not provided in writing to Blue Cross and Blue Shield of Alabama within the required time period, there will be no disability extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Blue Cross and Blue Shield of Alabama of that fact within 30 days after SSA's determination.

Second Qualifying Event

An extension of coverage for up to 18 months will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage.The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months (beginning on the date of the first qualifying event). Such second qualifying events may include the death of a covered employee, divorce from the covered employee, the covered employee's becoming enrolled in Medicare (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred.

For example, the former employee becoming enrolled in Medicare will rarely be a second qualifying event that would entitle the spouse or dependent children to extended COBRA coverage. This is so because, for plans that are subject to both COBRA and the Medicare Secondary Payer (MSP) laws, this event would not cause the spouse or dependent children to lose coverage under the plan had the first qualifying event not occurred.

In order for this extension to apply, you must timely notify the Plan Administrator in writing (using the procedures specified below) of the second qualifying event within 60 days after the second qualifying event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

Qualifying Event Notice Procedures: The notice of the second qualifying event that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or hand deliver your notice to the Plan Administrator at the address listed at the end of this notice. Your notice must be received by the Plan Administrator no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event, and
- the second qualifying event and the date of the second qualifying event.

If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, we have provided a form of Notice by Qualified Beneficiaries that you may use to notify the Plan Administrator of a second qualifying event. You may also get a copy of this form, at no cost to you, from the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA coverage as a result of the second qualifying event.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Failure to do so will result in the loss of the right to elect COBRA continuation coverage. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

In the case of an extension of COBRA coverage due to disability, the amount a qualified beneficiary may be required to pay may not exceed 150 percent of the full cost to the plan after the 18th month, assuming that the disabled qualified beneficiary elects to be covered under the disability extension. If the only qualified beneficiaries who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102 percent of the full cost of coverage.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the plan. Your first payment for continuation coverage must include all premiums owed from the date on which COBRA coverage began. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA Continuation Coverage Election Letter. The periodic payments can be made on a monthly basis.

Under the plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the plan will continue for that coverage period without any break. You will receive periodic notices of payments due for these coverage periods.

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Blue Cross and Blue Shield of Alabama
Attention: COBRA
P.O. Box 361346
Birmingham, AL 35236-1346

For more information

This notice does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact the Plan Administrator below.

For more information about your rights under ERISA,including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Contact Information

Plan Administrator: ____________________

Name/Position: ____________________

Address: ____________________

Phone Number: ____________________

COBRA

CONTINUATION OF COVERAGE APPLICATION

BlueCross BlueShield
of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001
(205) 988-2200

COBRA CONTINUATION OF COVERAGE APPLICATION

FOR OFFICE USE ONLY

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended.

EMPLOYEE INFORMATION

PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK BALL POINT PEN - PRESS FIRMLY)

*** INDICATES REQUIRED FIELDS**

○ DR. ○ MR. ○ MRS. ○ MS.

HEALTH GRP. NO. * | HEALTH DIV. NO. | HEALTH CONTRACT NUMBER *

DENTAL GRP. NO. * | DENTAL DIV. NO. | DENTAL CONTRACT NUMBER *

LAST NAME * | FIRST NAME *

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | SOCIAL SECURITY NUMBER *

ADDRESS ☐ BILLING ☐ MAILING

CITY | STATE | ZIP

DATE OF BIRTH (MM/DD/YYYY) * | PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL | ☐ MALE ☐ FEMALE

E-MAIL ADDRESS (Optional)

COBRA APPLICANT INFORMATION

(If different from above)

LAST NAME * | FIRST NAME *

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | SOCIAL SECURITY NUMBER *

ADDRESS ☐ BILLING ☐ MAILING

CITY | STATE | ZIP

DATE OF BIRTH (MM/DD/YYYY) * | PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL | ☐ MALE ☐ FEMALE

E-MAIL ADDRESS (Optional)

REASON I CAN CONTINUE COVERAGE

(Check one)

○ Death ○ Divorce ○ Legal Separation (when applicable)

○ No Longer An Eligible Dependent ○ Termination/Reduction in Hours

○ Employee is entitled to Medicare (when applicable)

DATE EVENT OCCURRED (MM/DD/YYYY) *

COORDINATION OF BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by any other group health insurance, please give the following information.

NAME OF CONTRACT HOLDER	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY	GROUP NUMBER

EMPLOYER'S NAME	NAME OF INSURANCE COMPANY

BLUE CROSS AND BLUE SHIELD COPY
TOP COPY

EMPLOYER COPY
MIDDLE COPY

EMPLOYEE COPY
BOTTOM COPY

MEDICARE BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by Medicare, please give the following information.

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

○ PART A (MM/DD/YYYY EFFECTIVE DATE) / /

○ PART B (MM/DD/YYYY EFFECTIVE DATE) / /

○ PART D (MM/DD/YYYY EFFECTIVE DATE) / /

LIST ELIGIBLE DEPENDENTS TO BE SHOWN ON THE CONTINUATION COVERAGE AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of your Group Plan.

LAST NAME

FIRST NAME *

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER * - -

RELATIONSHIP ○ SPOUSE ○ OTHER ______________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ______________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ______________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ______________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

TRANSFER COVERAGE — A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

○ I acknowledge that I have received and read a COBRA notice informing me of my COBRA rights.

○ I understand and acknowledge that it is the Employer's obligation (and not Blue Cross') to provide me with any and all continuation coverage to which I might be entitled under COBRA or under the provisions of the Employer's group health plan implementing COBRA. I further understand and acknowledge that my COBRA benefits are provided to me under and in accordance with the provisions of Part 6 of Title I of the Employee Retirement Income Security Act of 1974. In the event of a dispute between me and Blue Cross regarding my benefits under COBRA or under this application, I understand that any administrative remedies available under the Employer's group plan must be used and exhausted by me before bringing any action against Blue Cross, notwithstanding cancellation of the Employer's coverage.

By signing below, I agree to pay to Blue Cross and Blue Shield of Alabama the monthly premium to continue the group benefits for me and my eligible dependents, if any, who are listed above. I can continue COBRA coverage for 18 months following my termination of employment or reduction in hours or 36 months if my coverage was terminated for any other event listed above. Under certain circumstances explained in the COBRA notice, if I or a member of my family is or becomes disabled during the first 60 days of COBRA coverage, the 18 month period may be extended to 29 months.

I understand the first payment is due by 45 days after I first elected COBRA. The first payment must include all premiums retroactive to the effective date of my COBRA coverage. All other payments are due within 30 days of the due date. If I fail to pay the amount due on time or if I request that my coverage be cancelled, my coverage will end and not be reinstated under any circumstances.

I understand that coverage will end for me or any of my dependents who become covered by Medicare or any other group health coverage which does not have limitations or exclusions for pre-existing conditions or which has them but they do not apply.
I will notify you in writing if I become covered by another group plan or Medicare. If I or any of my qualified dependents become disabled according to the Social Security Administration (SSA), I will notify you in writing before the end of the 18 month period and within 60 days after the later of the date of my initial qualifying date, the date on which my coverage is lost under my group health plan because of such event, or the date of the SSA disability determination.

While I continue the benefits provided by this group, these benefits are subject to all terms and conditions of the Employer's group health plan and any agreement between the Employer and Blue Cross and Blue Shield of Alabama. My benefits and/or rates will change when this Employer's benefits change, and will end if the Employer's coverage is cancelled at the same time benefits for active employees of the Employer end, regardless of whether I have continued to pay for my coverage.

I wish to continue the following coverage:

○ **HEALTH ONLY**
○ **HEALTH AND DENTAL**
○ **DENTAL ONLY**

○ *Enclosed with the application is a check or money order for the premium payment to cover the period from the effective date of my COBRA Coverage through the current coverage period.*

SIGNATURE OF APPLICANT * ______________________________

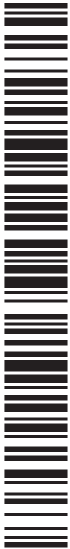
PRINT APPLICANT NAME ______________________________

APPLICANT'S SOCIAL SECURITY NUMBER *
☐☐☐ - ☐☐ - ☐☐☐☐

DATE SIGNED ______________________

TO BE COMPLETED BY EMPLOYER

I am authorized by the Employer named below to certify that the person named above is eligible under COBRA to continue group health plan coverage to be effective for a maximum of __________ (18 or 36) months. The monthly rate for the continuation coverage will be $ _________._____ per month until notified by Blue Cross and Blue Shield of Alabama under the conditions noted above.



EMPLOYER NAME
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMPLOYER PHONE NUMBER
(☐☐☐) ☐☐☐ - ☐☐☐☐

EXTENSION
☐☐☐☐

COBRA EFFECTIVE DATE (MM/DD/YYYY) *
☐☐ / ☐☐ / ☐☐☐☐

DATE OF TERMINATION/LAYOFF (MM/DD/YYYY) (If Applicable) *
☐☐ / ☐☐ / ☐☐☐☐

SIGNATURE OF AUTHORIZED REPRESENTATIVE * ______________________________

PRINTED AUTHORIZED REPRESENTATIVE NAME ______________________________

DATE SIGNED ______________________

BLUE CROSS AND BLUE SHIELD COPY
TOP COPY

EMPLOYER COPY
MIDDLE COPY

EMPLOYEE COPY
BOTTOM COPY

Important Information About Your COBRA Premiums

Blue Cross and Blue Shield of Alabama administers benefits for COBRA subscribers so long as their former employer maintains coverage by our company. This information is provided to inform you of important information as it relates to the administration of your COBRA coverage. The information is general because the COBRA law and regulations are complex. If you have a question about your eligibility for COBRA coverage, please call your group. If you have a question about payment for COBRA coverage after you are enrolled in COBRA, please call our Customer Service Department at 1 800 292-8868.

BILLING

1. Please send your payment to Blue Cross promptly. Under COBRA regulations, Blue Cross will cancel your coverage when payment is not received within 30 days of the due date which appears on your bill. The only exception to the 30 day rule is the first payment due. You will have 45 days from election of COBRA to make the first payment. The first payment must include all premiums due since the effective date of your COBRA coverage. After the first payment, you will receive monthly invoice statements showing the monthly COBRA premium amount due. If the monthly COBRA premium amount shown to be due on the invoice statement does not match the monthly COBRA premium amount you received from your group, please call our Customer Service Department at 1 800 292-8868. If your coverage is cancelled because payment has not been received within the appropriate time frame, Blue Cross will not reinstate your COBRA coverage.

2. Each year rates for your group may increase. If this happens, your COBRA rates will also increase. Depending on when Blue Cross is notified and any new benefit issues are settled to establish new rates, you may be retroactively billed the rate increase.

3. If your check is returned to Blue Cross due to insufficient funds and we do not receive payment in full within 30 days of the due date which appears on your bill, your contract will be cancelled and will not be reinstated. If your check is returned to Blue Cross due to insufficient funds after 30 days of the due date, your contract will be cancelled and will not be reinstated.

4. If your former employer's coverage is cancelled with Blue Cross, then your COBRA coverage through Blue Cross is also cancelled. Likewise, if your former employer changes coverage to another carrier then your COBRA coverage by Blue Cross will be cancelled. You will be referred to your group for information on COBRA coverage by your new carrier.

PAYMENT PROCESSING

Your health is important to us and we want to make sure you continue receiving the best coverage available. Here are four simple steps you can take to ensure continuous coverage while you are enrolled under your COBRA coverage:

1. Pay the exact amount due by the due date. Your payment is considered past due by the delinquent date.

2. If you do not receive a statement by the first of the month, please call our Customer Service Department at 1 800 292-8868 to arrange payment.

3. Always write your contract number(s) on your check.

4. If you have health and dental coverage, return both statements with a separate check for each coverage. Remember to put your contract number(s) on both checks.

CHANGES TO YOUR COBRA COVERAGE

Any eligibility changes due to your COBRA coverage will be in accordance with the guidelines established by your group and must be reported to Blue Cross promptly.

1. To change your COBRA coverage from family to individual, your spouse must write us a letter that includes his or her signature, requesting to be removed from your COBRA coverage. If your spouse is being removed from your COBRA coverage because of a divorce or legal separation, the spouse may be eligible for an extension of COBRA coverage. Please refer to the COBRA Continuation Coverage Election Notice for more information about how to qualify for an extension of COBRA coverage in this case.

2. Address changes must be reported to us immediately by phone or letter.

3. Notify us if you become covered by any other group coverage or by Medicare.

PLEASE DETACH AND RETAIN THIS PAGE

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-216-3144（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。