

**IMPORTANT:** Please read instructions on reverse before completing this application



Regence BlueCross BlueShield of Utah, Regence HealthWise and Regence ValueCare are independent licensees of the Blue Cross and Blue Shield Association

## COBRA CONTINUATION OR STATE EXTENSION APPLICATION

(Instructions on reverse side)

<b>EMPLOYEE INFORMATION</b>	<input type="checkbox"/> COBRA CONTINUATION <input type="checkbox"/> STATE EXTENSION OF BENEFITS (6 months only)
	Employee/Subscriber Name _____ Employee/Subscriber Identification Number _____ Employer (or Former Employer) Name _____ Group Number _____

<b>EMPLOYEE INFORMATION</b>	Reason for election (Qualifying Event): <input type="checkbox"/> Employee/Subscriber's termination of employment or reduced working hours <input type="checkbox"/> Employee/Subscriber's Medicare entitlement <input type="checkbox"/> Employee/Subscriber's death <input type="checkbox"/> Employee/Subscriber's divorce or legal separation <input type="checkbox"/> Employee/Subscriber's child's loss of dependent status <input type="checkbox"/> Former Employer's bankruptcy
	Date of Qualifying Event (Last day of group coverage): _____

<b>QUALIFIED BENEFICIARIES</b>	If the qualifying event is termination of employment or reduction in working hours, is coverage to be continued for the Employee/Subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No Coverage is to be continued for:									
	Qualified Beneficiaries' Names	Date of Birth Mo/Day/Yr	Social Security Number	Relationship to Employee/ Subscriber	(For HealthWise, HMOBlue and HealthPoint only) Primary Care Physician Selected	Other Group Health/Dental/Drug Coverage (Information including Medicare)				
						Carrier Name	Medical	Dental	Drug	
	1.	/ /								
	2.	/ /								
	3.	/ /								
	4.	/ /								
	5.	/ /								
	Qualified Beneficiaries' Mailing Addresses:									
	Name _____				Name _____					
	Street _____				Street _____					
	City _____		State _____		ZIP Code _____		City _____		State _____	

<b>SIGNATURE</b>	I authorize any source to release to Regence BlueCross BlueShield of Utah, Regence ValueCare and/or Regence HealthWise (hereafter referred to as "the Plan") any medical, health, employment and/or insurance information requested. I agree to abide by the Plan's enrollment regulations.	If applying for Regence HealthWise benefits, I understand that each covered family member must select a participating Primary Care Physician (PCP). Regence HealthWise must coordinate all medical care.  I understand there may not be participating physicians available in all fields.
	Signatures of Qualified Beneficiaries _____ (Parent may sign for qualified dependent child beneficiary.) _____	Date _____

## INSTRUCTIONS

### GENERAL INFORMATION

- Please print your answers in either black or blue ink in all blanks.
- Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A".
- Be sure to sign and date the form.

### EMPLOYEE INFORMATION

- Be sure to include the subscriber identification and group numbers of the coverage to be continued.

### REASON FOR ELECTION

- Please check the reason continued coverage is requested and, under "Date of Qualifying Event," include the termination date of the group coverage.

### QUALIFIED BENEFICIARIES

- Please list the name, birthdate (month, day and year), Social Security number and Relationship to Employee/Subscriber of every qualified beneficiary requesting continuation of coverage. This may include the Employee/Subscriber if the Reason for Election is termination of employment or reduction in working hours. If a Regence HealthWise, HMOBlue or HealthPoint program is selected, include the name of each beneficiary's Primary Care Physician.
- For every beneficiary covered by another group plan, including BlueCross BlueShield and Medicare, complete the appropriate health/dental/drug carrier name and policy number. Make sure complete information is given for every beneficiary covered by other plans.

### SIGNATURE

- Each qualified beneficiary must sign this application. A parent may sign for dependent children.
- Please include the date application was completed.

### PRE-EXISTING CONDITIONS

- Any coverage issued in connection with this application may contain a limitation on the coverage of pre-existing conditions. If you have prior creditable coverage, it may be available to reduce the period of the pre-existing condition limitation. Regence BlueCross BlueShield of Utah will assist you in obtaining a certificate of creditable coverage if necessary.