COBRA Form (See reverse side for instructions)

Benefits are administered by SelectHealth, Inc. and underwritten (insured) by SelectHealth Benefit Assurance Company, Inc.

A. EMPLOYEE INFORMATION

❑ I would like to enroll in COBRA

Employer Name _____ Name (Last, First, Middle Initial) _____ Sex ❑ Male ❑ Female

Social Security# _____ Street Address _____ City _____ State _____ ZIP _____

Work Ph# (_____)_____ Home Ph# (_____)_____ Marital Status ❑ Single ❑ Legally Married ❑ Divorced ❑ Widowed ❑ Separated

Employee Name Last _____ First _____ Middle Initial _____ Social Security# _____

If you are not the employee, please list the name, Social Security # and your relationship to the employee under whom you were previously covered in Section B.

B. COVERAGE INFORMATION

Complete the following information in full. List yourself and all eligible dependents (spouse and children) you wish to be covered. Children should be listed in order of age. **List relationship of children** as son/daughter; step son/step daughter. Please use one line per individual. If you need additional space, use another COBRA Form. Any dependents not listed will not be covered.

NOTE: You may elect to continue only those benefits for which you were enrolled before the qualifying event for yourself and any eligible dependents

	NAME OF MEMBER TO BE COVERED (LAST, FIRST, MIDDLE INITIAL)	COVERAGE Medical	Dental	Eyewear	SEX M	F	DATE OF BIRTH (MM/DD/YY)	RELATIONSHIP	SOCIAL SECURITY#
1	Yourself								
2									
3									
4									
5									
6									

Is your ex-spouse required to pay your dependent's medical expenses in a divorce decree? ❑ Yes ❑ No

If yes, you must attach a copy of the divorce decree with this form. You should include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

Will you have other health insurance? ❑ Yes ❑ No (If yes, complete the information below.)

	MEMBER TO BE COVERED	CARRIER	PH#	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICYHOLDER NAME
1					
2					
3					

C. SIGNATURE

I hereby apply for membership under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and make such application for the persons listed on this application (herein referred to as applicants) and agree to submit to the employer through whom I have been offered this coverage prepayment fees as required by SelectHealth/SelectHealth BAC. I understand the initial prepayment fees must be received within 45 days of this election. I understand that if I fail to make my monthly payments in accordance with the rules set forth by the employer group, my coverage will cease as of the end of the period for which payment was made and cannot be reinstated. I accept the terms of the group agreement between the employer and SelectHealth/SelectHealth BAC. I understand that said agreement is on file with the employer and SelectHealth/SelectHealth BAC and is available for my inspection. I understand that intentional material misrepresentation in answering the questions on this application or nonpayment of prepayment fees, coinsurance, or copays may result in recision or cancellation of my coverage and that of my dependents. I understand that the length of time that I may be covered will depend on the nature of the qualifying event, that qualified me for coverage, and that my benefits may be affected by changes in the employer's group plan.

I represent that the information on this form is true. I understand that no agent or SelectHealth/SelectHealth BAC representative is allowed to permit me to answer any questions inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to SelectHealth/SelectHealth BAC any change in the eligibility of any applicants who become members.

Employee Signature _____ **Date** _____

D. EMPLOYER SECTION

Qualifying Event Information

The employee is eligible for continuation or health coverage due to (check one):

- ❑ Employee termination _____ /_____ /_____
- ❑ Reduction in working hours of employee
- ❑ Death of the employee _____ /_____ /_____
- ❑ Employee became eligible for Medicare _____ /_____ /_____ (additional information may be required)
- ❑ Divorce or annulment _____ /_____ /_____
- ❑ Dependent no longer meets eligibility requirements _____ /_____ /_____
- ❑ Transfer from previous carrier's coverage (If coming from previous carrier COBRA plan), Please specify qualifying event information and coverage period information.)

Coverage Period Information

Date of Qualifying Event

_____ /_____ /_____

Qualifying Event Coverage Period

- ❑ 18 Months
- ❑ 36 Months

Date Coverage Expires

_____ /_____ /_____

Extension of COBRA Coverage

Length of Extension _____ months

Date COBRA Started and Expires:

From _____ To _____

Reason for Extension _____

_____

Note: If you are extending coverage because of a disability, you must attach a copy of the Social Security Administration Determination letter with this form.

Last Day of Regular Group Coverage _____ Effective Date _____ Company Number _____

Comments _____

Employer Approval _____ Date _____

selecthealth

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BENEFIT ASSURANCE COMPANY

P.O. Box 30192 Salt Lake City, UT 84130-0192 **800-538-5038** **selecthealth.org**

COBRA Form Instructions

FORM INSTRUCTIONS

All areas are to be completed in detail by you and/or the employer. It is your responsibility to read and understand this information and follow the instructions given. Please print legibly. Application and forms that are illegible or incomplete will be delayed.

The following instructions will usually answer any questions that you may have. If you need more help, contact a Human Resources/Personnel representative at the employer through whom you are receiving coverage. To contact SelectHealth Member Services, call **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users, please call 711.

A. Employee Information – Complete the employee information. If you are not the employee, you must complete the name, Social Security number, and your relationship to the employee in Section B.

B. Coverage Information – Individually list those persons that you want covered.

C. Signature – Please read the information in this section carefully. Sign and date to complete this form.

D. Employer Section – An authorized representative of the employer group should complete this section.

- "Qualifying Event Information" – Indicate the reason for this continuation coverage.
- "Coverage Period Information" – Enter the date of the qualifying event, and mark the box for the qualifying event coverage period. Also mark the date that the COBRA expires.
- "Extension of COBRA Coverage" – Complete the length of extension, the beginning and ending dates of the COBRA, and the reason for the extension.
- The "Effective Date" is the exact date coverage is to begin.
- The "Company Number" is assigned by your employer. If the employer group is new to SelectHealth/SelectHealth BAC, leave this space blank, and the number will be assigned. If the employer group has previously been assigned a number by your employer, write that number in the space provided. (See left corner of billing invoice for "Company Number".)
- The "Comments" section may be used to communicate miscellaneous information to SelectHealth/SelectHealth BAC.
- The signature of the employer's representative and the date signed must be completed to validate the application. Such employer approval also indicates your agreement to pay all prepayment fees as required by SelectHealth/ SelectHealth BAC.

ADDITONAL INFORMATION

- A Change Form indicating plan member(s) termination from regular group coverage must precede or accompany submission of this form.
- If you were previously enrolled on a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), SelectHealth may have submitted your eligibility and claims' information to an HSA vendor. If you become eligible on a COBRA plan, SelectHealth will no longer submit this information for you. In addition, you may be billed for HSA administrative costs. Please contact your HSA vendor for details.