

COBRA Form (See reverse side for instructions)

A. EMPLOYEE INFORMATION

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 complete the name, Social Security #, and your relationship to the employee under whom you were previously covered.

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

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; stepson/stepdaughter. 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			SEX		DATE OF BIRTH (MM/DD/YY)	RELATIONSHIP	SOCIAL SECURITY#
		Medical	Dental	Eyewear	M	F			
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. 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. I understand that said agreement is on file with the employer and SelectHealth and is available for my inspection. I understand that intentional material misrepresentation in answering the questions on this application or nonpayment of prepayment fees may result in rescission or cancelation 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 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 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 _____

Employer COBRA Checklist Instructions

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.

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.

A. Qualified Beneficiary Information – Complete this section with information about the qualified beneficiary.

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.

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. Mark the date that COBRA expires.
- "Extension of COBRA Coverage" – Complete the length of extension, the beginning and ending dates of the COBRA coverage, 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, 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.
- 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.

ADDITIONAL INFORMATION

- A Change Form indicating plan member(s) termination from regular group coverage must precede or accompany submission of this form to SelectHealth.
- 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 for COBRA, 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.

Employer's COBRA Obligation

COBRA coverage is the employer obligation, not the obligation of SelectHealth. SelectHealth is not the administrator of COBRA coverage procedures and requirements. SelectHealth has contractually agreed to assist the employer in providing COBRA coverage in certain circumstances. It is the employer's responsibility to do the following in a timely manner:

- Notify persons entitled to COBRA coverage;**
- Notify SelectHealth of such individuals; and**
- Collect and submit all applicable premiums to SelectHealth.**

If the employer's contract with SelectHealth is terminated, any member's COBRA coverage with SelectHealth will terminate. The employer is responsible for obtaining substitute coverage.