



An Anthem Company

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Ī	THIS SECTION MUST BE COMPLETED	
	Employee Member Number	
	Health Group Number	
	Dental Group Number	
	Vision Group Number	
	ents. See your employer for eligibility. To apply for continuation of Medical, Dental nt of termination of employment).	ı

## **COBRA or State Continuation of Coverage Application**

Continuation of Medical, Dental or Vision benefits may be available for you and/or covered Dependents. See your employer for eligibility. To apply for continuation of Medical, Dental or Vision benefits, complete and return this form to your Employer (or previous Employer in the event of termination of employment).										
TO BE COMPLETED BY EMPLOYER	RONLY									
Employee Name (First, Middle Initial,	Last)	_								
Employer Name		_		D	ate of Hire					
STATE CONTINUATION OF COVERAGE (Applicable to employers with less than 20 employees and church and federal government groups)  COBRA (Applicable to employer with 20 or more employees)										
FOR STATE CONTINUATION OF COVERAGE OR WHEN THE EMPLOYER DOES COBRA BILLING IF YOU ELECT TO CONTINUE COVERAGE PAYMENT MUST BE SENT TO:										
PAYABLE ON OR BEFORE THE DAY OF EACH MONTH COMMENCING ON IN ORDER TO AVOID CANCELLATION OF YOUR COVERAGE.										
THE MONTHLY PREMIUM FOR COVERAGE AS ELECTED ABOVE IS \$ FOR MEDICAL \$ FOR VISION AND \$ FOR DENTAL.										
THERE MAY BE AN ADDITIONAL 2% ADDED				R UP TO 50% FOR COBRA DISAI IP COVERAGE		RIES.  EPENDENT NOTIFICATION DATE				
		43104	- C	- COVERAGE	EMPLOTEE/DI	- Company Notification Bate				
GROUP ADMINISTRATOR SIGNAT	URE				DATE					
TO BE COMPLETED BY EMPLOYE	3									
DATE OF QUALIFYING EVENT			7-		•					
QUALIFYING EVENT										
EVENT FOR EMPLOYEE										
EVENT FOR EMPLOYEE ☐ Bankruptcy of Employer ☐ Termination of Employment ☐ Work Related Disability ☐ Reduction in Hours										
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☐ Termination of Employment ☐ Non-medical Leave of Absence	; [	Wor	k Related		=	n in Hours e Entitlement				
Non-medical Leave of Absence	; ; ;	] Wor ] Non	k Related -work Rela	Disability ated Disability	Medicare	e Entitlement				
Non-medical Leave of Absence		] Wor ] Non ] Ban	k Related -work Rela kruptcy of	Disability ated Disability	Medicare					
■ Non-medical Leave of Absence  EVENT FOR DEPENDENT  ■ Death of Covered Employee	tus C	] Wor ] Non ] Ban ] Divo	k Related -work Rela kruptcy of orce or Leg	Disability ated Disability Employer gal Separation ndividuals to be covered und	Medicare  Employe	e Entitlement e's Entitlement to Medicare and the coverage desired.				
■ Non-medical Leave of Absence  EVENT FOR DEPENDENT  Death of Covered Employee  Child's Loss of Dependent Sta	tus C	Wor Non Ban Divo	k Related -work Rela kruptcy of orce or Leg	Disability ated Disability Employer yal Separation	☐ Medicare	e Entitlement e's Entitlement to Medicare				
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It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

You are hereby notified that as a terminated employee, or an employee who has lost group coverage because of a reduction in work hours, you have the right to elect to continue group coverage for yourself and your dependents, if applicable, for a maximum period of 18 months. This coverage may end sooner if you become covered under another group plan which does not contain a pre-existing condition limitation (COBRA and State Law), or the employer discontinues coverage for active employees, or premium is not paid when due, or you become entitled to Medicare benefits including Medicare Disability, (COBRA and State Law), or Medicaid benefits (State Law), or cause exists that would result in termination of this coverage for a similarly situated active employee. The 18 months may be extended to 29 months for a terminated member if the member is determined under the Social Security Act to have been disabled any time during the first 60 days from the employee's termination or reduction in hours; however, coverage may end on the date on which the member is determined under the Social Security act to no longer be disabled (COBRA).

You are hereby notified that as a legally separated or divorced spouse, or a spouse/dependent of a deceased employee, (COBRA or State Law) or a spouse/dependent of an employee who selected Medicare as his/her primary coverage COBRA leaving you without coverage, or a dependent who is no longer eligible under the employee's coverage, you have the right to elect to continue group coverage for a maximum period of 36 months (COBRA) or 18 months (State Law). This coverage may end sooner if you become covered under another group plan which does not contain a pre-existing condition limitation (COBRA and State Law), or the employer discontinues coverage for active dependents, or premium is not paid when due, or you become entitled to Medicare benefits including Medicare Disability (COBRA and State Law), or Medicaid benefits (State Law) or cause exists that would result in termination of this coverage for a similarly situated active dependent.

If group coverage is discontinued for active employees' dependents, the COBRA or State Law will also be discontinued as of the dame effective date the group is discontinued. Any premiums paid beyond that date will be refunded to the member.