



To: Group Accounts Department

From: Group Name _____ Group/Section No. _____

Part I Application For COBRA First Qualifying Event

Name of Subscriber: _____

Name and Social Security number of Applicant (if not Subscriber): _____; SSN _____ - _____ - _____

Individual number(s) under which applicant had coverage: Health _____; Dental _____

Select Coverage being applied for: [] Health [] Dental

Applicant is requesting continuation of coverage pursuant to COBRA due to the following reason (check applicable box):

- 1. Continued coverage for a maximum of 18 months due to employee's reduction in work hours, retirement or termination on _____. (Specify last work day)

Coverage requested for:

- [] Employee and all dependent(s) listed on prior group coverage
[] Employee and specific dependent(s) listed on prior group coverage
[] Employee only (Complete Enrollment Application/Change Form to drop dependents - Required)
[] Dependent(s) only, if listed on prior group coverage - (Complete Enrollment Application/Change Form - Required)

Should a dependent with continued coverage for a maximum of 18 months experience a second qualifying event during this period, they may be eligible to extend their coverage. See the reverse side of this form for details.

- 2. Dependent coverage continuation for a maximum of 36 months due to the following (Complete Enrollment Application/Change Form - Required):
[] Death of employee on _____
[] Finalized date of divorce from employee on _____
[] Dependent child ceasing to meet the dependent requirements of your group contract (e.g. age limit). Please give reason and date of loss of dependency status: _____ (Reason) _____ (Date)
[] Employee's coverage cancelled as a result of becoming entitled to Medicare benefits on _____. Only dependent coverage to be continued.
3. [] Continued coverage as a result of the employer filing a Title XI bankruptcy proceeding on _____ as long as the employer continues to provide coverage for any of its employees. Applicant must have been covered as an employee, dependent, a retiree, a dependent of a retiree, or a surviving spouse of a retiree.

Are you or any member of your family covered by A. Medicare [] Yes [] No Type of Other Group Coverage [] Health [] Dental

OR B. Any other group Health or Dental Insurance [] Yes [] No Eff. Date of Other Coverage ____/____/____ Month Day Year

If the answer to A or B is Yes complete the remainder of this section

Name of Policyholder Mo. Day Yr. of Birth Relationship to Applicant [] Self [] Spouse [] Child

Group/Policy Number ID Number Name(s) of Person(s) Covered

Name and Address of Other Health Care or Dental Carrier Phone No. Other Group Employer's Name

I have read this Application for COBRA continuation of coverage and I certify the information stated hereon is correct. I understand that coverage under any other group health plan (which does not contain any applicable exclusion or limitation with respect to any pre-existing condition) or entitlement to Medicare will terminate the continued coverage. I understand this application does NOT provide any life or disability insurance coverage. I understand that Blue Cross and Blue Shield of Texas' or HMO Blue Texas' use or disclosure of individually identifiable health information whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulation under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Signature of Applicant (Date)

Applicant's Home Address No. and Street Name City State ZIP

See reverse side for COBRA second qualifying event or state continuation of coverage for dependents.

Part II Application for COBRA Second Qualifying Event

Name of Subscriber: _____
 Name and Social Security number of Applicant (if not Subscriber): _____; SSN ____-____-____
 Identification number(s) under which applicant had coverage: Health _____; Dental _____
 Select Coverage being applied for: Health Dental

Applicant is requesting an extension of continued coverage due to the occurrence of a second qualifying event during the 18-month period of continued coverage. If approved, the Applicant will be entitled to continued coverage for a period (which began on the effective date of the continued coverage) not to exceed **36** months. The second qualifying event was the following **(Complete Enrollment Application/Change Form - Required)**:

- Finalized date of divorce from employee _____.
- Death of former employee on _____.
- Dependent child ceasing to meet the dependent requirements of the group contract. Please give reason and date of loss of dependency status: _____ (Reason) _____ (Date).
- Former Employee's coverage cancelled as a result of being entitled to Medicare Benefits on _____. Only dependent coverage to be continued.

Are you or any member of your family covered by A. Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">OR</p> B. Any other group Health Care Coverage or Dental Insurance	Type of Other Group Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Eff. Date of Other Coverage ____/____/____ Month Day Year
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If the answer to A or B is Yes complete the remainder of this section

Name of Subscriber	Mo	Day	Yr. of Birth	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Group/Policy Number	ID Number	Name(s) of Person(s) Covered		
Name and Address of Other Health Care or Dental Coverage			Phone No.	Other Group Employer's Name

I have read this Application for COBRA continuation of coverage and I certify the information stated hereon is correct. I understand that coverage under any other group health plan (which does not contain any applicable exclusion or limitation with respect to any pre-existing condition) or entitlement to Medicare will terminate the continued coverage. I understand this application does NOT provide any life or disability insurance coverage. I understand that Blue Cross and Blue Shield of Texas' or HMO Blue Texas' use or disclosure of individually identifiable health information whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulation under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Signature of Applicant and Home Address No. and Street Name _____ City _____ State _____ ZIP _____ (Date) _____

Part III State Continuation of Coverage For Dependents

Name of Applicant: _____
 Certificate number under which Applicant has coverage: _____
 Applicant is requesting continuation of dependent coverage for three years pursuant to Texas legislation due to the following reason (check applicable box) **(Complete Enrollment Application/Change Form - Required)**:

- Employee retired on _____ and, as a result, dependent coverage was cancelled.
- Employee died on _____.
- Finalized date of divorce from employee _____.

I have read this Application for state continuation of coverage and the information stated hereon is correct. I understand that substantially similar coverage under any other health policy or contract will terminate the continued coverage and I certify that no one applying for the continued coverage has obtained such other health coverage. I also understand this application does NOT provide any life or disability insurance coverage.

Signature of Applicant and Home Address No. and Street Name _____ City _____ State _____ ZIP _____ (Date) _____

I certify that the applicant and dependents (if applicable) are eligible to apply for continued coverage.

Signature of Group Representative (Date) _____

This Application must be SIGNED by BOTH the APPLICANT AND THE REPRESENTATIVE of the Group or the Application will be returned.