BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. ® Registered Marks Blue Cross Blue Shield Association.

Request For Continuation Coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 (C.O.B.R.A.)

Check the box that applies:
- ☐ Group Health only (if applicable)
- ☐ Group Dental only (if applicable)
- ☐ Group Health and Group Dental

Mail to:
Blue Cross and Blue Shield of Oklahoma
ATTN: Underwriting Department
P.O. Box 3283
Tulsa, OK 74102-3283

PART 1. TO BE COMPLETED BY THE EMPLOYER (PRINT IN INK OR TYPE)

GROUP NAME	GROUP NUMBER
GROUP ADMINISTRATOR'S SIGNATURE	TODAY'S DATE

PART 2. TO BE COMPLETED BY THE APPLICANT REQUESTING COVERAGE (EMPLOYEE, SPOUSE, CHILD)

NAME Last First Middle	SOCIAL SECURITY NUMBER	TOTAL NUMBER OF PERSONS TO BE COVERED UNDER THIS POLICY
ADDRESS Street or Box No. City State Zip Code		RESIDENCE TELEPHONE

DATE OF BIRTH	SEX ☐ M ☐ F	MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	RELATIONSHIP TO EMPLOYEE ☐ Self ☐ Spouse ☐ Ex-spouse ☐ Child ☐ Other

NUMBER OF QUALIFYING EVENT FOR COVERAGE	DATE OF QUALIFYING EVENT	NAME OF EMPLOYEE COVERAGE IS CURRENTLY UNDER	SOCIAL SECURITY NUMBER OF EMPLOYEE

ARE THERE ANY DEPENDENTS THAT YOU WISH TO COVER THAT ARE ELIGIBLE FOR CONTINUATION? ☐ YES ☐ NO
If YES, please complete Part 3 below.
If NO, skip to Part 4.

PART 3. LIST ALL CURRENTLY ENROLLED SUBSCRIBERS TO BE COVERED UNDER THIS POLICY, INCLUDING SELF *(Attach second form, if necessary)*

NAME (First, Middle, Last)	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME (First, Middle, Last)	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME (First, Middle, Last)	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME (First, Middle, Last)	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SOCIAL SECURITY NUMBER

PART 4. APPLICANT SIGNATURE

ARE YOU, OR ANY SUBSCRIBER APPLYING FOR COBRA, COVERED BY ANY OTHER HEALTH INSURANCE OR MEDICARE? ☐ YES ☐ NO
If YES, list below subscriber(s) covered along with name of insurance company.

SUBSCRIBER NAME	INSURANCE COMPANY	POLICY NUMBER	SUBSCRIBER NAME	INSURANCE COMPANY	POLICY NUMBER
SUBSCRIBER NAME	INSURANCE COMPANY	POLICY NUMBER	SUBSCRIBER NAME	INSURANCE COMPANY	POLICY NUMBER

CONVERSION OPTION

You and/or your eligible dependents may apply for conversion coverage following termination of your continuation coverage, provided you exercise your conversion privilege within 31 days of the date your coverage terminates and your employer's group contract is still in force.

I CERTIFY THAT ALL STATEMENTS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.
*APPLICANT'S SIGNATURE TODAY'S DATE

*A parent or guardian MUST sign for a dependent under 18 years of age

LIST OF QUALIFYING EVENTS

FOR EMPLOYEE
1. **Termination of employment**
2. **Reduction in number of hours worked**

Coverage may continue for a period not to exceed 18 months from the date of the qualifying event. **

A second qualifying event that takes place during this period may extend coverage to a maximum of 36 months for persons who were covered at the date of the qualifying event. Additionally, coverage **may be extended up to 29 months for persons determined to be disabled by the Social Security Administration within the first 60 days of COBRA coverage.

FOR DEPENDENT
3. **Death of employee**
4. **Divorce or legal separation from the employee**
5. **Employee's entitlement to Medicare**
6. **Dependent ceases to meet the group contract definition of "dependent"**

Coverage may continue for a period not to exceed 36 months from the date of the qualifying event. **

**However, if one of the following events occurs, the 18, 29 or 36 month limit will not apply and coverage will end on the earliest of the following dates:
1. the date the plan sponsor ceases to provide any employee group health plan; or
2. the last date of the grace period for which monthly premium is due; or
3. The date you become covered under another group health plan, and you have satisfied the preexisting condition exclusion provision under the new plan.

FOR OFFICE USE ONLY

GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVA CODE	WVA CODE EXP DATE	PROD. CODE	DIVISION CODE	COBRA TERM. DATE

MSC CODE	EFFECTIVE DATE	SUB CHAR.	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR.	DEP. DENT. CHAR.

LOB	LOB	LOB	LOB	LOB	LOB	LOB	LOB	LOB	LOB	APPROVED