FEDERAL "COBRA"
CONTINUATION COVERAGE FORM

_____
(Date Notified)

To: _____ _____
(Name of Employee or Qualified Beneficiary) (Now covered under I.D. #)

From: _____ _____
(Name of Group) (Group Number)

RE: Right to Continuation Coverage

This is to advise you that you and/or your covered family members have the right to continuation coverage under the employer's group health plan. Each person covered on the day your health plan is terminated can elect continuation coverage. Your group health plan might include other options, such as dental or cancer coverage. Consult the Group Administrator to determine if you are eligible.

You must exercise this right by notifying your employer within 60 days from the date your coverage terminates because of a "qualifying event" or from the date you receive this notice, whichever is later. Your coverage will terminate as a result of a qualifying event. When your election notice is received, your coverage will be reinstated.

As a result of the "qualifying event", your coverage terminates _____. Therefore, continuation coverage will end _____.

You and/or your covered dependents are entitled to continuation coverage for the specified time because of the following qualifying event. If it is for 36 months, a new Enrollment Form and Request for Change Form must be completed.

18 Months

(◯) Termination of employment
(◯) Loss of coverage due to reduction in work hours

36 Months

(◯) Death of employee
(◯) Divorce/Separation From Employee
(◯) Ineligible dependent child
(◯) Medicare-ineligible spouse/children

The monthly premium due for continuation coverage is $ _____ for subscriber only coverage; $_____ for employee and dependent coverage, provided your dependents were previously insured. These applicable rates can include 102 percent of the group premium amount of 150 percent of the group premium amount for disability.

You must submit the monthly premium to our company no later than the _____ of each month. Failure to pay premiums timely will result in cancellation.

Certain disabled qualified beneficiaries can have an 11-month extension from 18 months to 29 months. To qualify, a qualified beneficiary must be determined by the Social Security Administration to be disabled as of the termination or reduction in hours of employment or within sixty (60) days thereafter. In order to qualify for the 11-month extension, the Plan Administrator (employer) must be notified within 60 days after the SSA notice of disability. In addition, that notification to the employer must be made during the initial 18-month coverage period, while Cobra coverage remains in force. In such cases, the qualifying beneficiary may be charged 150 percent of the group fee for the 11-month extended period. The Plan Administrator must forward the award letter to the insurance carrier for an additional 11 months of coverage. The affected individual must also notify the Plan Administrator within thirty (30) days of any final determination that the individual is no longer disabled.

TO BE COMPLETED BY EMPLOYEE/QUALIFIED BENEFICIARY

I acknowledge receipt of the above notice of right to continuation coverage.

For myself and family members, if any, I elect

(◯) Not to have continuation coverage

(◯) To have continuation coverage, and understand that I am responsible for payment of the entire premium amount/102 percent of the group premium or 150 percent of the group premium for disability.

I understand that continuation of coverage ceases at the expiration of the allowed time period. It can end earlier in case of the following:

1. **All of the employer's health benefit programs are terminated.**
2. **A qualified beneficiary becomes covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary.**
3. **A qualified beneficiary becomes entitled to Medicare after the date of the continuation coverage election. [If a qualified beneficiary is already entitled to Medicare before the qualifying event, the qualified beneficiary is entitled to elect COBRA]**
4. **A qualified beneficiary fails to pay a required premium in a timely manner.**
5. **A qualified beneficiary with coverage for up to 29 months due to disability has received a final determination that the individual is no longer disabled.**

Signature: _____
EMPLOYEE/QUALIFIED BENEFICIARY

Date Signed: _____

BlueCross BlueShield of Mississippi