State Continuation of Coverage

19 or Fewer Part-Time & Full-Time Employees

(Please read carefully. Your response is time-sensitive.)

Date: _____

Employer: _____

Address: _____

City, State ZIP: _____

RE: State Continuation of Coverage form for: _____

After termination of employment, the employee may be entitled to State Continuation of Coverage for health benefits. To ensure continuation of benefits, please read over the following list of requirements.

- Applicant/Dependent MUST have been insured on the active group for three consecutive months before the date of coverage ended
- No waiting period, insured must accept coverage on or before the date insurance ends
- Coverage lasts for 12 months
- Does not include dental insurance
- Does not include life insurance
- Insured is 100% responsible for payment of premium
- Must be paid through bankdraft only

Required form(s) are enclosed.

BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

STATE CONTINUATION OF COVERAGE ELECTION FORM

THIS FORM MUST BE COMPLETED BY THE EMPLOYER AND THE EMPLOYEE.

STEP 1: EMPLOYER – COMPLETE THIS SECTION

Indicate the appropriate monthly premium and the day of the month each premium payment is due in the areas provided for that information. Sign and date where indicated below. Keep a copy for your file and give this original to the Employee who is terminating.

NAME OF EMPLOYER GROUP	NUMBER OF EMPLOYEES (full and part-time)	GROUP NO.
FORMER EMPLOYEE'S EFFECTIVE DATE OF COVERAGE	DATE FORMER EMPLOYEE'S GROUP COVERAGE WILL END	
TYPE OF COVERAGE ☐ Single ☐ Employee/Spouse ☐ Two-Party ☐ Family ☐ Employee/Child	MONTHLY PREMIUM	DAY OF MONTH PREMIUM BANK DRAFT IS DUE

I attest that the information provided above is correct.

X_____ _____

EMPLOYER SIGNATURE DATE

STEP 2: ELECTION OF STATE CONTINUATION OF COVERAGE

This form contains important information about your right to continue your healthcare coverage under your current Group Benefit Plan for a maximum of 12 months. Details regarding State Continuation of Coverage are provided in your Employer Group Benefit Plan.

SUBSCRIBER'S NAME	PHONE#	SUBSCRIBER ID#	
ADDRESS	CITY	STATE	ZIP CODE

NAME(S) OF CONTINUING DEPENDENT(S)	RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY #

(continued on next page)

STEP 3: SUBSCRIBER BANK DRAFT AUTHORIZATION AGREEMENT

Do not include a payment or check with this form.

THE ACCOUNT FROM WHICH THE BANK DRAFT WILL BE MADE MUST HAVE CHECK-WRITING PRIVILEGES WITH CHECKS PAYABLE THROUGH A U.S. FINAICIAL INSTITUTION.

First Name **M.I.** **Last Name** **Suffix**

Social Security Number

Depository Bank or Branch Name

City **State** **Zip Code**

Please list all of the numbers (to include characters and spaces) that appear at the bottom of your check in the spaces below.

Through your signature at the end of this form, you agree to authorize Blue Cross & Blue Shield of Mississippi (BCBSMS) to initiate monthly debit and credit entries to your Checking Account at the Depository Bank for the premium for this Benefit Plan, which may be changed at the direction of BCBSMS. If your requested effective date is prior to the date of this application, the appropriate premium will be drafted from your account within 5 business days of our receipt of this application. The Depository Bank is hereby authorized to initiate, and continue until otherwise notified, debit entries in the amount of the premium for this Benefit Plan. This authority remains in full force for the duration of your State Continuation of Coverage or until BCBSMS and Depository Bank have received written notification from you of the termination of this authorization in such time and in such manner as to afford BCBSMS and the Depository Bank reasonable opportunity to act.

STEP 4: COMPLETION OF STATE CONTINUATION OF COVERAGE ELECTION FORM

Sign and date where indicated below. Send this form to the following address on or before the date that your coverage will end under your Benefit Plan:

Blue Cross & Blue Shield of Mississippi
ATTN: Membership Department
P.O. Box 2312
Jackson, MS 39215-2312

If you have any questions about this notice or your rights to State Continuation of Coverage, please refer to your Employer Group Benefit Plan.

Please keep Blue Cross & Blue Shield of Mississippi informed of any changes in your address. For your convenience, you can change your address online at www.bcbsms.com under the "i'm a member" tab. You should also keep a copy, for your records, of any notices you send to Blue Cross & Blue Shield of Mississippi.

I have read and understand the terms and conditions as set forth in this form. I further understand that my monthly premium rate, as indicated in the Employer section of this form, is payable by bank draft directly to Blue Cross & Blue Shield of Mississippi on the day also indicated in the Employer section. I understand that I am responsible for maintaining sufficient funds in the bank account designated above to cover my monthly premium rate on the date indicated in the Employer section, or my coverage will be terminated. I also understand that my coverage will terminate if my former employer's group coverage terminates and that my premium amount and available benefits will be adjusted if my former employer's group coverage premium or benefits are adjusted.

X_____ _____

AUTHORIZED SIGNATURE (SUBSCRIBER & BANK ACCOUNT OWNER) DATE

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