

COBRA ENROLLMENT FORM

- Federal COBRA (medical and/or dental)
- Cal-COBRA AB1401 (medical only)

Effective Date _____ Group No. _____ Department No. _____

(SHADED SECTIONS I, II, III AND VIII ARE REQUIRED)

I: PERSONAL INFORMATION

Last Name (Print) _____ First Name (Print) _____ M.I. _____ 1 Male
2 Female

Street Address _____ City _____ State _____ ZIP _____

Telephone No. _____ Email Address _____

III: EMPLOYEE & FAMILY INFORMATION Please list below the family members that were covered under your previous group health plan that you wish to continue coverage under either Federal COBRA or Cal-COBRA.

Sex	Last Name	First Name	M.I.	Date of Birth
Self				Month Day Year
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				Month Day Year
Child				Month Day Year
Child				Month Day Year
Child				Month Day Year
Child				Month Day Year

IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION INCLUDING MEDICARE (if applicable)

Name	Name and Address of Other Insurance Carrier	Effective Date
Self		Month Day Year
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		Month Day Year
Dependent #1 Above		Month Day Year
Dependent #2 Above		Month Day Year
Dependent #3 Above		Month Day Year
Dependent #4 Above		Month Day Year

V-VII: CONTINUATION OF GROUP HEALTH COVERAGE

V. You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space at the end of Section VII of this form; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Blue Cross of California, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

- The date eligibility for COBRA Continuation Coverage ends, as provided in Section VIII, or
- The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
- The date your employer discontinues coverage with Blue Cross of California, or
- The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
- The date you become covered under another group health plan as a result of employment, re-employment, remarriage or otherwise, unless that other group health plan contains an exclusion or limitation for a pre-existing condition for which you are covered under your current coverage with Blue Cross of California. In such a case, the date on which you would lose eligibility for Continuation Coverage with Blue Cross of California is the date full coverage becomes available to you under the other plan, without limitations or exclusions for pre-existing conditions.

If at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your selection of COBRA Continuation Coverage or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

VI. NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

II: SELECTED COVERAGE

Check the existing benefits you wish to continue

Medical

- HMO (CaliforniaCare)*
- Preferred HMO (CaliforniaCare Plus)*
- Power Advantage HMO*
- Power Select HMO (Select Network)*
- PPO (Prudent Buyer)
- Power CareAdvocate PPO
- EPO (Prudent Buyer Exclusive)
- POS (Blue Cross Plus)*

BlueCard PPO

BlueCard Exclusive

BlueCard Power CareAdvocate PPO

Medicare

Other _____

Dental (for Federal COBRA enrollees only)

- Choice Dental (Select One of the Following)
- Dental Net*
- Prudent Buyer
- Dental Net*
- Dental SelectHMO*
- Fee-For-Service Dental
- National Dental PPO
- Prudent Buyer Dental PPO
- PPO Dental Exclusive
- Other _____

COBRA coverage includes:

- Employee Only
- Employee and Dependents)
- Dependents) Only

If Enrollee is not (former) employee:
Employee Name _____
Employee's Social Security No. _____

* indicate Medical Group/IPA# in Section III
* indicate Dental Office # in Section III

MEDICARE SECTION

Age	Social Security Number	If Children are age 19 or over, you must check the appropriate boxes below	Qualifies as IRS Dependent	Full-Time Student	Totally Disabled	Medical Group/IPA#	Blue Cross HMO IPA Primary Care Physician Code	Is This Your Current MD?	Dental Office No.
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> YES <input type="checkbox"/> NO	

VIII: GROUP PLAN INFORMATION TO BE COMPLETED BY EMPLOYER AT THE TIME COBRA NOTICE IS PROVIDED TO ENROLLEE

Company Name _____ Group Number(s) _____

Employee:

- Termination of employment
- Reduction of Employee's work hours
- Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees.

Family Member:

- Death of the employee
- Divorce or legal separation from employee
- Loss of dependent child eligibility
- Employee's entitlement to Medicare
- Benefits terminated or reduced within one year before or after retired employee's employer filing bankruptcy, if plan provides benefits for retirees.

Date of Federal COBRA Qualifying Event	Date When Federal COBRA Continued Coverage Ends	Date Notice Given	Enrollee's initials upon receipt of notice
Cal-COBRA Effective Date	Date When Cal-COBRA Coverage Ends		

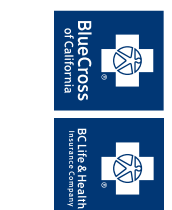
Signature _____ Title of Plan Holder Representative _____

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

VII. ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions: Understand that any and all disputes between myself and/or any enrolled family member) and Blue Cross of California/ BC Life & Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Blue Cross/BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross/ BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate. If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.), I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

Signature _____ Date _____

BLUE CROSS OF CALIFORNIA AND BC LIFE & HEALTH INSURANCE COMPANY ARE NOT YOUR COBRA ADMINISTRATOR. FOR QUESTIONS OR CONCERNS ABOUT YOUR COVERAGE, PLEASE CONTACT THE HEALTH PLAN ADMINISTRATOR AT YOUR PREVIOUS EMPLOYER.



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DISTRIBUTION: WHITE - Return this copy CANARY - Individual's copy PINK - Employer's copy



COBRA Enrollment Form

Federal COBRA/Cal-COBRA Worksheet Instructions

SECTION I: PERSONAL INFORMATION

Requested information is required.

SECTION II: SELECTED COVERAGE

Check the appropriate boxes. Requested information is required.

SECTION III: EMPLOYEE & FAMILY INFORMATION

Requested information is required.

Please check the **Totally Disabled** box only if the condition prohibits you/your dependent from working or performing daily activities.

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

For Blue Cross HMO and POS members only: Each person listed must receive all medical care through the Medical Group or Independent Practice Association he or she has selected in order to receive the HMO benefit, and must live or work within the service area of the group selected. Select a Primary Care Physician from the listing in your Provider Directory. You must indicate the Primary Care Physician number which is listed below the physician's name or after the address. (If you select an IPA, you must select a Primary Care Physician from within the IPA.)

For Dental Net and Blue Cross Dental SelectHMO only: Each family member needs to select a dental office (for Federal COBRA enrollees only).

SECTION IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE?

Please fill in requested information if applicable, including Medicare.

SECTIONS V-VII: CONTINUATION OF GROUP HEALTH CARE COVERAGE

Continuation of coverage. Authorizations. Please read and sign.

SECTION VIII: INFORMATION TO BE COMPLETED BY EMPLOYER

Please fill in requested information and sign.