COBRA SELECTION FORM

FOR CONTINUATION OF GROUP COVERAGE WITH CAREFIRST BLUECROSS BLUESHIELD OR CAREFIRST BLUECHOICE, INC.

The Consolidated Omnibus Budget Reconciliation Act of 1985, also known as "COBRA", requires that a group health plan sponsored by an employer who typically employs 20 or more employees offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") at group rates, in certain instances where coverage under the plan would otherwise end ("qualifying events"). Certain employer-maintained group health plans are exempt from COBRA, including small-employer plans, church plans (or tax-exempt organizations controlled by or affiliated with a church), and government plans (the Public Health Service Act governs governmental plans and contains parallel provisions of the federal law). Generally, if a member qualifies for continued coverage, he or she must pay the full cost of the applicable coverage during this period, and any applicable administrative fee. If the qualifying member wishes to continue coverage beyond this period, he or she may apply directly to CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. for direct pay non-group conversion coverage within 31 days after his or her continued group coverage ends. (Dental, drug and eye care programs are not available under the direct pay non-group conversion coverage.)

In general, an employer must notify the health plan administrator within 30 days after an employee's "qualifying event" – death, job termination, reduced hours of employment, or eligibility for Medicare. In cases of divorce, legal marital separation, or a child's loss of dependent status, it is the employee or his or her family's responsibility to notify the health plan administrator within 60 days of the event. Once notified, the plan administrator then has 14 days to alert the employee and his or her family members about applicable rights to elect COBRA coverage. In turn, the employee, spouse, and children have 60 days to decide whether to buy COBRA coverage. **Please note that neither CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., nor their representatives act as the health plan administrator. This form is not an application for insurance. <u>This form is for data collection purposes only.</u> The above description of COBRA and COBRA procedures is general in nature.**

NAME OF PARTICIPANT(S): _____

_____

_____

IDENTIFICATION NO.: _____

SOCIAL SECURITY NO.: _____

PARTICIPANT'S ADDRESS: _____

HOME TELEPHONE NO.: ( )_____ WORK TELEPHONE NO.: ( )_____

GROUP NAME: _____ GROUP NUMBER:_____

PARTICIPANT'S STATEMENT

I understand and agree that in the event I cease to be eligible for continuation of group coverage, I will immediately notify the employer through whom I have continued coverage.

Signature of Participant and Date _____

TO BE COMPLETED BY PLAN ADMINISTRATOR

1. I HEREBY CERTIFY THAT THE PARTICIPANT HAS BEEN PROPERLY NOTIFIED OF ALL RIGHTS AND RESPONSIBILITIES AS DICTATED BY FEDERAL STATUTE.

2. TYPE OF QUALIFYING EVENT: _____

3. DATE CONTINUATION OF COVERAGE BECOMES EFFECTIVE FOR THE PARTICIPANT: _____

4. $ _____ IS THE AMOUNT THAT THE PARTICIPANT HAS BEEN TOLD MUST BE REMITTED EACH MONTH FOR CONTINUATION OF GROUP COVERAGE.

5. CONTINUED GROUP COVERAGE MUST END NO LATER THAN: _____

Signature of Plan Administrator and Date_____

PLEASE RETURN THIS FORM TO:

CAREFIRST BLUECROSS BLUESHIELD / CAREFIRST BLUECHOICE, INC.
ENROLLMENT & BILLING
10455 MILL RUN CIRCLE
OWINGS MILLS, MD 21117
MAIL STOP 02-330

CUT5870-1S (3/02)