BlueCross BlueShield of Texas

Group Administered Texas Six (6) Month State Continuation of Insurance Application Form (Post-COBRA)

Who is Eligible?

Any individual who was covered under a group health plan either as the employee, the spouse of the employee, or the dependent child of the employee and has completed their continuation coverage under COBRA is eligible for an additional six (6) months following any period of continuation coverage provided under COBRA.

Who is not Eligible?

You or your enrolled dependents are not eligible for state continuation if:

1) The termination of coverage occurred because you failed to pay any required premium;
2) Any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days of the discontinuation;
3) You are or could be covered by Medicare;
4) You are covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy, hospital or medical service subscriber contract, medical practice plan, or any other prepaid plan or any other group plan or program;
5) You are eligible for similar benefits whether or not covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
6) Similar benefits are provided or available to you under the requirements of any state or federal law.

How to Apply?

The completed application must be submitted to your prior employer no later than sixty (60) days after the later of: (1) the date the group coverage would otherwise terminate; or (2) the date you are given notice of the right to continuation of group coverage. Payment of the first month's premium must be submitted to your prior employer within forty-five (45) days after the initial election of coverage. Following the initial election of coverage, the monthly premium must be received no later than thirty (30) days after the premium due date.

Explanation of Your State Continuation Coverage

Continuation of coverage under the employee's health benefit plan will continue for a maximum of six (6) months. The premium will be 102% of the group premium. At the end of the six months, no other continuation options will be available.

The state continuation coverage will be effective on the day after termination of the group coverage. You will be given credit for time satisfied toward preexisting waiting periods and any charges that were applied to current deductibles and coinsurance amounts. Likewise, all amounts applied to lifetime maximums will be transferred to the state continuation coverage.

This six (6) month state continuation coverage may not terminate until the earliest of:

1) Six months after the date the employee, member, or dependent elects to continue the group coverage;
2) The date failure to make timely payments would terminate the group coverage;
3) The date the group coverage terminates in its entirety;
4) The date the insured is or could be covered under Medicare;
5) The date the insured is covered for similar benefits by another plan or program, including:
   (a) a hospital, surgical, medical, or major medical expense insurance policy;
   (b) a hospital or medical service subscriber contract; or
   (c) a medical practice or other prepayment plan;
6) The date the insured is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
7) The date similar benefits are provided or available to the insured under any state or federal law.

If you have questions regarding your rights for continuation of your health insurance, contact Blue Cross and Blue Shield of Texas toll-free at (800) 521-2227. If you have additional questions, you may contact the Texas Department of Insurance toll-free at (800) 252-3439.

Si usted tiene una pregunta sobre sus derechos bajo el proceso de continuar el seguro de salud, hable Blue Cross and Blue Shield of Texas, por el numero gratis (800) 521-2227. Si usted necesita mas informacion, se puede comunicar con el Departmento de Seguros de Tejas por el numero gratis (800) 252-3439. Se habla espanol.

BlueCross BlueShield of Texas

PO Box 655082
Dallas, TX 75265-5082

GROUP ADMINISTERED TEXAS SIX (6) MONTH STATE CONTINUATION OF INSURANCE APPLICATION FORM

☐ I hereby accept State Continuation - Same Benefits (Maximum Coverage of 6 months)
or

☐ I hereby decline

Last Name	First		Middle Initial
Street Address	City	State	Zip Code
Sex: ☐ Male ☐ Female	Date of Birth: Mo/Day/Year / /	Social Security Number - -	Telephone Number ( ) -

Group No.	Subscriber ID Number	Coverage Termination Date / /	Original effective date of plan or coverage to be continued (if less than 3 consecutive months, you are not / /

List Full Name of All Dependents To Be Covered ☐ Husband ☐ Wife	**Date of Birth** / /	**Social Security No.** - -
Complete ***ONLY*** if different from applicant's address Street Address City State ZIP		
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -
Complete ***ONLY*** if different from applicant's address Street Address City State ZIP		
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -
Complete ***ONLY*** if different from applicant's address Street Address City State ZIP		
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -
Complete ***ONLY*** if different from applicant's address Street Address City State ZIP		
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -
Complete ***ONLY*** if different from applicant's address Street Address City State ZIP		
Name of Dependent ☐ Son ☐ Daughter	**Date of Birth** / /	**Social Security No.** - -
Complete ***ONLY*** if different from applicant's address Street Address City State ZIP		

I understand that I am applying for coverage. I certify I have read the continuation material furnished by the Employer, and I am eligible for coverage. All information given on my Application is true and correct. I understand and agree: (1) any incorrect statements material to the eligibility for coverage shall invalidate the coverage, and (2) although I have applied for coverage listed on the Application, only those coverage(s) for which I or my Dependents are eligible will be available to me.

I understand that I have the sole obligation to pay the required premiums within forty-five (45) days of the due date. If I fail to pay such premiums within that time, the continued coverage may be cancelled as of the last day for which premiums were paid.

I authorize any Hospital, practitioner or other health care provider to give Blue Cross and Blue Shield of Texas (BCBSTX), upon request, any information concerning the health condition of any covered person whenever BCBSTX considers such information necessary for proper disposition of a claim submitted for payment.

I understand that Blue Cross and Blue Shield of Texas' (BCBSTX) use or disclosure of individually identifiable health information whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulation under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Applicant Signature: _____ Date: _____

----------For Employer Group Representative Use Only----------

I certify and understand that, to the best of my knowledge, the applicant and dependents (if applicable) are eligible to apply for continued coverage.

_____ _____

Signature of Group Representative Date

This application must be signed by BOTH the APPLICANT AND THE REPRESENTATIVE of the Group or the Application will be returned.