

BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

MEDICAL PLAN TYPE

- ☐ BLUE PREFERRED (PPO)
☐ BLUE PREFERRED SAVER (PPO)
☐ BLUE CLASSIC (INDEMNITY)
☐ BLUECHOICE (HMO)
☐ BLUE SELECT (HMO)

OPTION

MEDICAL COVERAGE

- ☐ ELECTOR ONLY
☐ ELECTOR & SPOUSE
☐ ELECTOR & CHILD(REN)
☐ FAMILY

DENTAL CHOICE COVERAGE

- ☐ ELECTOR ONLY
☐ ELECTOR & SPOUSE
☐ ELECTOR & CHILD(REN)
☐ FAMILY

DATE OF EVENT (MM/DD/YYYY)

EVENT TYPE:

- ☐ TERMINATION OF EMPLOYEE EMPLOYMENT
☐ REDUCTION OF EMPLOYEE HOURS
☐ DEATH OF EMPLOYEE
☐ DIVORCE OR LEGAL SEPARATION
☐ EMPLOYEE ENTITLED TO MEDICARE
☐ NO LONGER ELIGIBLE AS A DEPENDENT

SECTION I - INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME

LOCATION

GROUP NUMBER

SECTION II - INFORMATION REGARDING THE ELECTOR

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

M.I.

APARTMENT NO.

MAILING ADDRESS (NUMBER & STREET)

CITY

STATE

ZIP + FOUR

HOME TELEPHONE (AREA CODE AND NO.)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE MARRIED SINGLE DIVORCED

ELIGIBILITY STATUS OF ELECTOR

- ☐ FORMER EMPLOYEE ☐ SPOUSE ☐ DEPENDENT CHILD OF FORMER EMPLOYEE ☐ FORMER SPOUSE

EMAIL ADDRESS

Complete the following for all dependents. If you have more than 3 dependents, complete a separate form.

LAST NAME

FIRST NAME

M.I.

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

RELATIONSHIP

LAST NAME

FIRST NAME

M.I.

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

RELATIONSHIP

LAST NAME

FIRST NAME

M.I.

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

RELATIONSHIP

I certify that I am authorized to and hereby elect the selected benefits. I understand and agree that (1) services rendered during the initial COBRA election period will not be considered as a benefit under COBRA coverage until my initial premium payment is received; (2) if at any time, COBRA premiums are not received in a timely manner, coverage will be terminated and will not be reinstated; (3) if after electing COBRA, I and/or any covered dependents become entitled to Medicare or become covered under a group health plan which does not have a limitation or an exclusion for pre-existing conditions, COBRA coverage may be terminated (4) I am responsible for providing BCBSAZ written notice of any changes in my or my dependent's eligibility, address, dependent status, marital status and disability status; (5) I understand that if BCBSAZ, its reinsurers, and their authorized representatives need to obtain medical information for claims processing, I am responsible for any costs associated with obtaining such medical information. Personal information may be collected from someone other than me or one of the listed applicants. and (6) this application is part of the Group Master Contract between your employer and Blue Cross Blue Shield of Arizona. By signing below, I certify that the information provided is complete and accurate to the best of my knowledge.

I UNDERSTAND THAT THIS COVERAGE IS SUBJECT TO THE LIMITATIONS AND RESTRICTIONS OF APPLICABLE STATE AND FEDERAL LAW, INCLUDING BUT NOT LIMITED TO, THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED. SEE REVERSE SIDE FOR ADDITIONAL IMPORTANT INFORMATION.

X

SIGNATURE OF ELECTOR

DATE (MM/DD/YYYY)

BlueCross
BlueShield
of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

www.azblue.com

COBRA
EMPLOYEE
APPLICATION

TO BE COMPLETED BY EMPLOYER

DATE OF COBRA NOTIFICATION (MM/DD/YYYY)

DATE COVERAGE ENDS (MM/DD/YYYY)

DATE OF ELECTION (MM/DD/YYYY)

DATE ELECTION RECEIVED (MM/DD/YYYY)

As an authorized representative of employer, I understand that employer, as Plan Administrator, is solely responsible for administration of COBRA including, but not limited to, notice requirements, eligibility and coverage option determinations.

NAME (please print)

SIGNATURE

DATE

Please read the following carefully. Once signed on the reverse, and accepted, this application including all enrollment forms become a part of the Blue Cross Blue Shield of Arizona (BCBSAZ) contract with your employer group. If you have any questions concerning this information, please talk with your group's health plan administrator.

COBRA Information Sheet

Under Federal Law, the Consolidate Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), most employers who offer group health plans are required to offer employees and their covered family members the opportunity for temporary extension of health coverage (continuation coverage) at group rates in certain instances where coverage under such plan would otherwise end. Under Federal Law and the terms of the Group Master Contract between your employer and Blue Cross Blue Shield of Arizona, it is the employer's responsibility to inform employees and their covered family members of the availability, terms and conditions of continuation coverage available to them under COBRA.

You must check with your employer to determine whether your group coverage qualifies as a group health plan subject to COBRA, and, thus, whether you qualify for COBRA continuation coverage. Under COBRA your continuation coverage may be cut short for any of the following five reasons:

1. Your employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid timely;
3. You become covered under another group health plan after electing COBRA that does not contain any exclusion or limitation with respect to any preexisting condition you may have;
4. You become entitled to Medicare after electing COBRA; or
5. You extended coverage from the initial 18-month period for up to 29 months due to disability and there is a final determination after the end of the initial 18-month period that you are no longer disabled.

If you have any questions about the law or your rights under COBRA, please contact your employer. Also, if you have changed marital status, if you, your spouse, or covered dependent children have changed addresses, or if any other information relating to your eligibility for COBRA changes, please notify the employer.

COBRA Terms:

Elector: The individual who is applying for continuing COBRA coverage as the result of a specific qualifying event. The elector may be the employee, spouse, former spouse or dependent child of the employee.

Contract holder: The name of the individual appearing on your current Blue Cross Blue Shield of Arizona identification card under which you, the elector, are covered.

Other Insurance Coverage: If you or anyone you have identified to be covered on the application have additional insurance coverage either through employment or through a governmental program, it is necessary to identify such coverage before your request for COBRA continuation coverage can be processed.

Pre-existing Condition Waiting Periods

BCBSAZ group health plans (except BlueSelect) impose a preexisting condition waiting period exclusion. This means if you had a medical condition before coming to the group plan, you might have to wait a certain period of time before this plan will provide coverage for that condition. Most applicants for COBRA coverage have already completed the required waiting period or have enough prior creditable coverage to eliminate the waiting period.

The pre-existing condition waiting period applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six month period prior to your enrollment date. For purposes of determining a pre-existing condition and a pre-existing condition waiting period, your enrollment date means the effective date of coverage under the group's health plan or the first day of the group's eligibility waiting, whichever is earliest. Generally, this six month period ends the day before my coverage under the group plan becomes effective. However, if the group plan imposes an eligibility waiting period for coverage, the six month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the group health plan within thirty-one days after birth, adoption or placement for adoption.

The waiting period may last up to eleven months (or if your group health plan permits late enrollment, up to eighteen months if you are a late enrollee) from your first day of coverage under the group health plan or the first day of your group's eligibility waiting period. However, you can reduce the length of the waiting period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition waiting period if there is no break in coverage of at least sixty-three days. To reduce the eleven month (or eighteen month) exclusion period by creditable coverage, you can give your group or BCBSAZ a copy of any certificates of creditable coverage that you have. If you are continuing your coverage with BCBSAZ, there is no need to submit a certificate of creditable coverage. If you don't have a certificate from your prior plan, but do have prior health coverage, the group or BCBSAZ will help you obtain a certificate. There are also other ways that you can show that you have creditable coverage. You can contact your group or BCBSAZ if you need help demonstrating prior creditable coverage.

Certain large group health plans may apply a lesser period of review for a pre-existing condition or a different length of waiting period. If so, this notice was provided at your initial enrollment and is included in your group's plan materials. If you have questions about preexisting condition waiting periods and creditable coverage, please contact your employer or Enrollment Services at 602-864-4456 or 1-800-232-2345, ext. 4456.

By including my email address on the reverse side, I am authorizing Blue Cross and Blue Shield of Arizona (BCBSAZ) to send me information via e-mail. You may change your e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.