



Blue Cross and Blue Shield of Oklahoma

REQUEST FOR CONTINUATION COVERAGE
Consolidated Omnibus Budget Reconciliation Act of 1985 (C.O.B.R.A.)

BlueLincs HMO is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma, a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

MAIL TO: BlueLincs HMO - COBRA Enrollment
P.O. Box 21128
Tulsa, OK 74121-1128

PART 1. TO BE COMPLETED BY THE EMPLOYER (PRINT IN INK OR TYPE)

GROUP NAME
GROUP NUMBER

PART 2. TO BE COMPLETED BY THE APPLICANT REQUESTING COVERAGE (EMPLOYEE, SPOUSE, CHILD)

NAME Last First Middle SOCIAL SECURITY NUMBER TOTAL NUMBER OF PERSONS TO BE COVERED UNDER THIS POLICY
ADDRESS Street or Box No. City State Zip Code RESIDENCE TELEPHONE
DATE OF BIRTH SEX MARITAL STATUS RELATIONSHIP TO EMPLOYEE
NUMBER OF QUALIFYING EVENT FOR COVERAGE DATE OF QUALIFYING EVENT NAME OF EMPLOYEE COVERAGE IS CURRENTLY UNDER SOCIAL SECURITY NO. OF EMPLOYEE
ARE THERE ANY DEPENDENTS THAT YOU WISH TO COVER THAT ARE ELIGIBLE FOR CONTINUATION? YES NO

PART 3. LIST ALL CURRENTLY ENROLLED MEMBERS TO BE COVERED UNDER THIS POLICY, INCLUDING SELF (Attach second form, if needed)

Table with 4 columns: NAME (First, Middle, Last), RELATIONSHIP TO EMPLOYEE, DATE OF BIRTH, SOCIAL SECURITY NUMBER. Contains 5 rows for listing members.

PART 4. APPLICANT SIGNATURE

ARE YOU, OR ANY MEMBER APPLYING FOR COBRA, COVERED BY ANY OTHER GROUP HEALTH INSURANCE OR MEDICARE? YES NO
If YES, list below member(s) covered along with name of insurance company.
Member Name Insurance Company Policy Number
AUTHORIZATION TO RELEASE AND FURNISH MEDICAL RECORDS
CONVERSION OPTION
I certify that all statements made on this form are complete and true to the best of my knowledge.
*APPLICANT'S SIGNATURE TODAY'S DATE
*A parent or guardian MUST sign for a dependent under 18 years of age.

LIST OF QUALIFYING EVENTS

For Employee 1. Termination of employment Coverage may continue for a period not to exceed 18 months from the date of the qualifying event.**
2. Reduction in number of hours worked
For Dependent 3. Death of employee Coverage may continue for a period not to exceed 36 months from the date of the qualifying event.**
4. Divorce or legal separation from the employee
5. Employee's entitlement to Medicare
6. Dependent ceases to meet the group contract definition of "dependent"
** However, if one of the following events occurs, the 18, 29 or 36 month limit will not apply and coverage will end on the earliest of the following dates:
1. the date the plan sponsor ceases to provide any employee group health plan; or
2. the last date of the grace period for which monthly premium is due; or
3. the date you become covered under another group health plan that does not contain any exclusion or limitation with respect to a preexisting condition applicable to you (or the date you satisfy the preexisting condition exclusion period under that plan); or
4. the date you become entitled to benefits under Medicare.
I do not want my group coverage continued. (See conversion option above) SIGNATURE TODAY'S DATE
GROUP ADMINISTRATOR'S SIGNATURE TODAY'S DATE