

Beneficiary Election Form to Continue Health, Dental, and Vision Benefits

Section 1 To be completed by the beneficiary. If you have any questions regarding the terms of your group coverage or any other COBRA questions, please contact your benefit administrator, usually your employer. Please keep one copy for your records and return two copies to the employer before the date shown as "Eligibility Expires On" in Section 2.

Section 1A

Beneficiary's Name _____

Beneficiary's Address _____ Daytime Telephone # _____

Please check applicable box

Yes No I elect to continue coverage as noted within Section 1C below under the COBRA plan. Complete Section 1B and 1C, **AND INCLUDE FIRST MONTHS PREMIUM WITH THIS APPLICATION.**

I have read this form and the notice of rights. I would like to decline my right to continuation of coverage under the COBRA plan.

Signature _____ Date _____

If you have chosen **not** to continue your present group insurance program, please indicate the applicable reason(s).

I have other insurance coverage. I am moving out-of-state.

If you are interested in receiving information on our individual health insurance plans, please call 1-800-585-0099 or, if in greater Portland area, 822-7878.

Section 1B

If the above individual in Section 1A is a dependent of an employee/former employee, please complete the following:

Employee Name (Last, first, middle initial) _____ Employee Certificate # _____ Dependent's Relationship to Employee _____

Section 1C

List all members whose coverage you want continued. Dependents who are eligible to make independent elections under COBRA and wish to do so, must complete separate election forms. You may cover only members who were covered under your group program.

Health	Dental	Vision	Last Name	Covered Member Legal First Name in Full	Middle Initial	Sex F/M	Social Security Number	Birthdate	Relationship to Employee (Self, Spouse or Child)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						M M D D Y Y	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						M M D D Y Y	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						M M D D Y Y	

Section 2 To be completed by the employer before mailing to the beneficiary.

Employer Name _____ Group Number _____

Employer Address _____

Beneficiary Name (Subscriber or Dependent Losing Coverage) _____ Date of Qualifying Event

M	M	D	D	Y	Y
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Certificate Number _____

Continued Coverage Date (Termination Date of Insurance)

M	M	D	D	Y	Y
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Date Eligibility Expires (60 Days for Loss of Coverage Due to the Event)

M	M	D	D	Y	Y
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Group Rates
Health \$ _____ Dental \$ _____ Vision \$ _____

Qualifying Event (Reason for Continuation) Check One:
 Surviving Spouse/Dependent Voluntary
 Termination or Reduction of Employee's Hours Involuntary
 Divorced Spouse
 Employee on Medicare
 Dependent Child
 Employer Filed Bankruptcy
Will be billed at 102% of Group Rate
Date Employer Sends Election Form to the Beneficiary

M	M	D	D	Y	Y
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Employer: Please keep one copy and send one copy to Anthem Blue Cross and Blue Shield, 2 Gannett Drive, South Portland, ME 04106.

Your Authorization

I am requesting coverage for myself and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage. I understand that each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Certificate of Coverage.

Applicant Signature **X** _____ Date

M	M	D	D	Y	Y
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