BCBSAZ ID NUMBER (existing member)

EMPLOYEE NUMBER (employer use only)

***MEDICAL PLAN TYPE** (SUCH AS: BLUEPREFERRED; BLUEPREFERRED HSA PLUS; BLUE SELECT; OR VARIOUS OTHER PLAN TYPES)

***MEDICAL PLAN OPTION** (SUCH AS: $1,000 90/70; $2,600 90/50; PLAN 10; OR VARIOUS OTHER PLAN OPTIONS)

DENTAL
◯ DENTAL } ______ OPTION

MEDICAL COVERAGE
◯ ELECTOR ONLY
◯ ELECTOR & SPOUSE
◯ ELECTOR & CHILD(REN)
◯ FAMILY

DENTAL 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

* Qualified COBRA beneficiaries may enroll only for the same coverage that was in effect at the time of the qualifying event, but do have the same rights as active employees to change coverage (such as during open enrollment periods). If you are unsure as to the plan for which you are eligible, please contact your plan administrator or BCBSAZ.

SECTION I - INFORMATION REGARDING YOUR EMPLOYER

EMPLOYER NAME	LOCATION	GROUP NUMBER

SECTION II - INFORMATION REGARDING YOUR EMPLOYEE

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 BCBSAZ has received my initial premium payment, in accordance with my employer's process for collection and remittance of COBRA premiums; (2) I am responsible for working with my employer and ensuring that BCBSAZ timely receives my premium payment; (3) if at any time, COBRA premiums are not received in a timely manner, coverage will be terminated and will not be reinstated; (4) if after electing COBRA, I and/or any covered dependents become entitled to Medicare or become covered under a group health plan, COBRA coverage may be terminated (5) I am responsible for providing BCBSAZ written notice of any changes in my or my dependents' eligibility, address, dependent status, marital status and disability status; (6) 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, and that personal information may be collected from someone other than me or one of the listed applicants, and (7) this application is part of the Group Master Contract between my 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, information and belief.

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 (MM/DD/YYYY)

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 Consolidated 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;
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 any dependent identified on page 1 has additional insurance coverage, either through employment, or through a governmental program, you must identify such coverage before your request for COBRA continuation coverage can be processed.

CONTRACT HOLDER'S E-MAIL ADDRESS

By including my email address on the reverse side, I am authorizing Blue Cross 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.