



Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

OREGON HEALTH PLAN CONTINUATION NOTICE (For individuals in group health plans of employers with less than 20 employees)

Note: These continuation rules apply only to Oregon groups not subject to federal COBRA continuation rules. Generally, COBRA rules apply to groups with 20 or more employees.

Employer should fill out blue lined areas before giving to employee or employee's dependent.

To _____ Date of this Notice _____
Name _____ Identification Number _____
(Covered Employee)

Qualifying Events

Group health coverage for you (and your dependents, if applicable) would normally end on _____ because of the Qualifying Event checked below. However, you and/or your covered dependents who are enrolled on the Plan immediately prior to the qualifying event and who are not covered by Medicare, may continue group health coverage, for up to nine months at your own expense based upon the qualifying event check below.

Oregon state insurance law requires that group medical (not dental) policies allow people whose coverage would ordinarily end under their group plan to continue coverage for up to nine months in certain situations. Regence BlueCross BlueShield of Oregon allows continuation in these situations:

- 1. A reduction of hours.
- 2. The employee's termination of employment.
- 3. The employee's dependents lose coverage because of employee's death.
- 4. The employee's dependent spouse or domestic partner loses coverage because of divorce or termination of domestic partnership.

Please note there is no dependent continuation for children who become ineligible for group coverage because of age or for dependents who lose coverage because the employee becomes eligible for Medicare.

Regence BlueCross BlueShield of Oregon will pay secondary if you are Medicare eligible. This also applies if you choose not to take Medicare coverage when you become eligible for Medicare.

Requirements to Continue Coverage

The following requirements must be met in order to continue coverage:

- a) The employee must have been covered through the group for at least three months immediately before coverage would have ended.
- b) The person applying for continuation of coverage must not be eligible for Medicare or any other medical plan.
- c) All eligible dependents covered through the group must also continue coverage.
- d) The applicant must complete this form and send it and the monthly payment to the group within 31 days of when coverage would have ended. (We will accept continuation premiums only if they are included in the group's regular monthly premium payment.)

Changes in Benefits and Premiums

If group health plan benefits change for the regular plan during the Continuation Period, Continuation coverage will also be changed in the same manner. Required monthly premiums may also change during the Continuation Period in the manner allowed by the law. The Continuation Applicant will be notified of any changes in benefits and/or premiums during the Continuation Period.

Length of Continuation Coverage

Continuation Coverage must start from the date that coverage would have normally ended. Subject to all other provisions of the Plan, the Continuation Period will end on the earliest of the following:

1. The last day of the coverage period for which premium is paid on time.
2. The last day of the coverage period a continuation enrollee becomes covered under Medicare.
3. The last day of the coverage period the group medical policy is terminated.
4. The day the 9 month continuation period ends.
5. The last day of the coverage period or when a dependent loses eligibility due to a loss of dependent status.

In order to elect the Continuation Coverage, each Continuation Applicant must do two things within 31 days of when coverage would have ended.

1. Complete and return the attached Oregon Health Plan Continuation Election Form (Form 9765) to:

2. Pay the Plan Administrator:

(a) the initial premium covering the period of time from the date that coverage would have normally ended through the end of the month in which the initial premium is paid.

NO CLAIMS WILL BE HONORED UNLESS THE INITIAL PREMIUM IS RECEIVED BY THE PLAN ADMINISTRATOR ON A TIMELY BASIS.

(b) the subsequent monthly premiums are due on the _____ of the month for which coverage is being purchased. If premiums are late, they will be returned and coverage will terminate at the end of the last month for which timely premiums were paid.

The current Monthly Premium Cost is: _____



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OREGON HEALTH PLAN CONTINUATION ELECTION FORM (For individuals in group health plans of employers with less than 20 employees.)

Employer should fill out blue lined areas before giving to employee or employee's dependent.

Select one of the boxes below. If you are electing not to apply for continuation coverage, select the first box then, sign, date, print name clearly, include group number and/or ID number and return this form to your Plan Administrator. If you are electing to apply for continuation coverage, check the second box, complete the rest of this form and return along with the application premium payment to your Plan Administrator within 31 days of the date regular coverage ends.

I acknowledge receiving an Oregon Health Plan Continuation Notice and elect not to apply for Oregon continuation coverage. _____ Date

_____ Signature

_____ Full Name (print clearly) _____ Group Number _____ ID Number

I acknowledge receiving an Oregon Health Plan Continuation Notice and elect to apply for continuation of group health plan coverage because of the following Qualifying Event:

Select the appropriate box below and give date of Qualifying Event.	
<input type="checkbox"/> 1) Reduction of hours	Date of Qualifying Event
<input type="checkbox"/> 2) Employee's termination of employment	Date of Qualifying Event
<input type="checkbox"/> 3) Employee's death	Date of Qualifying Event
<input type="checkbox"/> 4) Divorce or termination of domestic partnership	Date of Qualifying Event

I understand I must notify the Plan Administrator immediately at the address shown on the attached notice when I or any of my covered dependents become covered on Medicare.

IN ALL INSTANCES BELOW, LIST ALL MEMBERS TO BE COVERED. PLEASE PRINT OR TYPE.
Please note: Dependents may be continued only if enrolled on the group health plan on the date regular coverage ended. All eligible dependents enrolled on the plan at the end of regular coverage must be continued.

Applicant's Social Security Number	Marital Status						Sex		Birthdate			
	SGL	MAR	DP	WID	DIV	SEP	M	F	MO.	DAY	YR.	
Applicant's Last Name	First Name	Initial										
I am familiar with the eligibility provisions of the group policy and wish to enroll the following dependents.								Sex		Birthdate		
								M	F	MO.	DAY	YR.
Spouse or Domestic Partner's Last Name	First	Initial										
Child's Last Name	First	Initial										
Child's Last Name	First	Initial										
Child's Last Name	First	Initial										
Child's Last Name	First	Initial										
Child's Last Name	First	Initial										

Please specify the relationship to you of any person listed above whose last name is different than yours.

Is anyone covered by MEDICARE? YES NO

If YES, please be sure to complete the Medicare portion of OTHER INSURANCE INFORMATION on the back of this form.

PLEASE COMPLETE AND SIGN THE REVERSE SIDE.

To help reduce the cost of health care, your health coverage includes a Coordination of Benefits provision in accordance with Oregon state insurance regulations or Maintenance of Benefits provision. In order for us to process your claim(s), we need the following information to determine the primary carrier as prescribed by law. We routinely investigate to update our records.

Other Coverage Information

If you or any family members listed on this application have Medicare, is coverage: PART A PART B

Member	Effective Date	Medicare Number (Please include alpha prefix)	Reason for Medicare Entitlement

Are you or any family members covered by Medicare disability? NO YES PART A PART B

Do you or any family members listed on this application, have group or individual coverage other than the coverage referenced above?

Medical coverage? NO YES Dental coverage? NO YES Vision coverage? NO YES

Prescription (Rx) coverage? NO YES with Orthodontia? NO YES

**If the answer to any of the above questions is "Yes," please complete the section below.
If you have more than one additional policy, please provide this information on a separate sheet.**

P O L I C Y	Name of policyholder with other coverage	Relationship	Policyholder's birthdate	Name of other group coverage	Phone Number	
	Address of other coverage			City	State	ZIP Code
	This coverage is for: <input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Numbers that identify you to other Group Plan (Group ID, Member Numbers, etc.)	
	This plan covers: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Stepchild(ren) <input type="checkbox"/> Other					
	Please list names: Name of Employer					
				<input type="checkbox"/> Continuation <input type="checkbox"/> Active <input type="checkbox"/> Retiree	Effective Date	Termination Date

Child Custody Information

When parents are divorced or legally separated, insurance regulations stipulate which health plan carrier will be primary for dependent child(ren). The carrier covering the person with custody of the child(ren) or the person who was given financial responsibility for the health expenses of the child(ren) by a court decree is primary. If you or your spouse are divorced or legally separated or your domestic partnership is terminated, please indicate who has legal custody of your child(ren) below.

Name of Child(ren)	Father	Mother	Joint *	Other	Date Awarded (*Please send copy of court decree)	Has the parent WITHOUT custody been required by court decree to provide coverage for the dependent children? YES NO If "Yes," list other coverage provided
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> _____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> _____

I understand that no claims will be honored unless my initial premium is paid on time (see attached notice)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to; claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

For the protection of all of our members, knowingly providing us with false, incomplete or misleading information may result in our taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available by telephone request or on our Web site at www.or.regence.com.

Please Sign Here	Date Signed		
Residence and/or Mailing Address			
City	State	ZIP Code	Residence County
Work Phone Number			Home Phone Number