



Regence

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

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

Note: These continuation rules apply only to individuals enrolled in a group plan with a state continuation of coverage provision in its medical contract. To determine whether the group's medical contract contains a state continuation of coverage provision, check with your Employee Benefits Administrator.

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

To _____

Date of this Notice _____

Name _____
(COVERED EMPLOYEE)

Identification Number _____

Group health coverage for you (and your dependents, if applicable) would normally end on _____ because of the Qualifying Event checked below. You and/or your covered dependents, who were enrolled on the Plan immediately prior to the qualifying event, however, may be able to continue group health coverage for up to six months, at your own expense based upon the qualifying event checked below.

Qualifying Events

- 1. The employee's termination of employment.
- 2. The reduction of hours.
- 3. The employee's dependent spouse loses coverage because of divorce.
- 4. The employee's dependent spouse and/or dependent children lose coverage because of employee's death.
- 5. The dependent child no longer qualifies as a dependent under the eligibility.
- 6. The employee's illness or injury for which a Worker's Compensation claim has been filed.

Requirements to Continue Coverage

To continue coverage, the applicant must complete this form and send it 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 the group medical policy is terminated.
3. The day the six month continuation period ends.
4. Receipt of written notice that the terminated enrollee wishes to terminate coverage.

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 Washington Health Plan Continuation Election Form (Form 3243) to:

2. Pay the Employee Benefits 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 EMPLOYEE BENEFITS ADMINISTRATOR ON A TIMELY BASIS.

(b) the subsequent monthly premiums 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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Select one of the boxes below. If you are electing not to apply for continuation coverage, select the first box, sign, date and return this form to your Employee Benefits Administrator. If you are electing to apply for continuation coverage, check the second box, complete the rest of this form and return to your Employee Benefits Administrator within the time specified in the Health Plan Continuation Notice.

- I elect not to apply for Washington continuation coverage _____
Signature _____
Date
- or
- I elect to apply for continuation of group health plan coverage because of the Qualifying Event listed below.

Select the appropriate box below and give date of Qualifying Event.

<input type="checkbox"/> 1) Employee's termination of employment	Date of Qualifying Event
<input type="checkbox"/> 2) Employee's reduction of work hours	Date of Qualifying Event
<input type="checkbox"/> 3) Divorce *	Date of Qualifying Event *
<input type="checkbox"/> 4) Employee's death	Date of Qualifying Event
<input type="checkbox"/> 5) Child no longer qualifies as dependent under the eligibility terms of the Plan because of the following reason:	Date of Qualifying Event
<input type="checkbox"/> 6) The Employee's illness or injury for which a Workers Compensation claim has been filed.	Date of Qualifying Event

* Indicate date divorce final

In all instances below, list all members to be covered. Please print or type.

NOTE: Dependents may be continued only if enrolled on the group health plan on the date regular coverage ended.

Applicant's Social Security Number	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Single <input type="checkbox"/> Separated	Sex	Birthdate				
Applicant's Last Name	First Name	Initial	M	F	MO.	DAY	YR.

I am familiar with the eligibility provisions of the group policy and wish to enroll the following dependents. Stepchildren must reside in my home to be eligible.

Wife or Husband's Name			Sex		Birthdate		
			M	F	MO.	DAY	YR.
Oldest Child's Name	Last, If Different	First	Initial				
Child's Name-Last, If Different		First	Initial				
Child's Name-Last, If Different		First	Initial				
Child's Name-Last, If Different		First	Initial				
Child's Name-Last, If Different		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 Washington 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 Insurance 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 insurance plan		Telephone 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 <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

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.

Child Custody Information

If you or your spouse are divorced or legally separated, 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 child(ren)?	
						YES	NO
_____	<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, fraud or misrepresentation of material fact by me and/or the group for the purposes of defrauding Regence BlueCross BlueShield of Oregon may result in Regence BlueCross BlueShield of Oregon 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 telephone number ()			Home telephone number ()