Handbook of COBRA Regulations

SUMMARY OF RULES,
SAMPLE FORMS AND INSTRUCTIONS

7/2014

BlueCross BlueShield
of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INSIDE FRONT COVER

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SUMMARY OF COBRA NOTICE REGULATIONS

The following is a brief summary of the COBRA Notice Regulations. In this summary, we use the term "COBRA Notice Regulations" to refer to the final regulations under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), published by the U.S. Department of Labor on May 26, 2004. You may find a copy of the COBRA Notice Regulations at **http://www.dol.gov/ebsa/complianceassistance.html**. For legal advice about the COBRA Notice Regulations, please consult your legal counsel.

What are the COBRA Notice Regulations?
If you sponsor a group health plan that is subject to COBRA, the COBRA Notice Regulations set minimum standards for the **timing and content** of COBRA notices, provide **model notices** for the general and election notices, and require **two additional notices** to be given by the plan administrator of your group health plan.

What group health plans are subject to COBRA?
Not all group health plans are subject to COBRA. As a general rule, COBRA applies to all employer-sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan. If you are uncertain about whether your plan is subject to COBRA, you should consult with your legal counsel.

What must you do for your plan to comply with the COBRA Notice Regulations?
As plan administrator of your plan, you have the following notification responsibilities under COBRA:

- **General Notice**: You must timely send a General Notice of COBRA Continuation Coverage Rights to each covered employee and spouse within 90 days of enrollment in the plan.

  A sample General Notice of COBRA Continuation Coverage Rights (MKT-116), along with specific instructions on how and when to use this form, is included with this summary. This sample General Notice is based upon the model notice in the COBRA Notice Regulations. You will need to send the General Notice of COBRA Continuation Coverage Rights (MKT-116) and the Notice by Qualified Beneficiaries of Initial Qualifying Event (MKT-52) to each covered employee and spouse within 90 days of enrollment in the plan.

- **Update SPD**: There are times when a qualified beneficiary must give you timely notice of some initial qualifying events, second qualifying events and Social Security disability determinations to qualify for COBRA coverage or extended COBRA coverage. You must have **reasonable procedures** in your plan's SPD that tell them where, when and how to give these notices to the plan.

- **Election Notice**: You must timely send a COBRA Continuation Coverage "Election Notice" to each qualified beneficiary after a qualifying event.

  A sample of the documents included in the COBRA Continuation Coverage "Election Notice," along with specific instructions on how and when to use these forms, is included with this summary. The "Election Notice" is comprised of three pieces — COBRA Continuation Coverage Election Letter (MKT-53), COBRA Continuation Coverage Election Form (MKT-365) and Important Information about your COBRA Continuation Rights (MKT-54). This sample "Election Notice" is based upon the model notice in the COBRA Notice Regulations. This "Election Notice" is included in the Blue Cross and Blue Shield of Alabama "Election Packet" (MKT-171).

- **Notice of Unavailability**: When you receive a notice of an initial qualifying event, second qualifying event or Social Security disability determination from a qualified beneficiary and you determine that any person described in the notice is not eligible for COBRA coverage or for extended COBRA coverage, you must timely send a Notice of Unavailability of COBRA Continuation Coverage to each ineligible person.

  The COBRA Notice Regulations do not include a model notice. **A sample Notice of Unavailability of COBRA Continuation Coverage, along with specific instructions on how and when to use this form, is included with summary. You may order this notice from Blue Cross and Blue Shield of Alabama by stock number MKT-57.**

- **Notice of Early Termination**: If COBRA will end earlier than the maximum COBRA coverage period, you must timely send a **Notice of Early Termination of COBRA Coverage** to each qualified beneficiary.

  The COBRA Notice Regulations do not include a model notice.

- **Review Internal Processes**: Review your internal processes to ensure that you document your compliance with the COBRA Notice Regulations.

How will Blue Cross and Blue Shield of Alabama assist you in your compliance with the COBRA Notice Regulations?
As the plan administrator, you are responsible for offering and administering COBRA for your plan. Blue Cross and Blue Shield of Alabama will assist you in your compliance with the COBRA Notice Regulations by providing the following sample notices:

- General Notice of COBRA Continuation Coverage Rights (MKT-116).
- Notice by Qualified Beneficiaries of Initial Qualifying Event (MKT-52).
- COBRA Continuation Coverage Election Letter (MKT-53 — part of the “Election Notice” included in packet MKT-171).
- COBRA Continuation Coverage Election Form (MKT-365 — part of the “Election Notice” included in packet MKT-171).
- Important Information about your COBRA Continuation Coverage Rights (MKT-54 — part of the “Election Notice” included in packet MKT-171).
- Notice by Qualified Beneficiaries of Second Qualifying Event (MKT-55 / included in Election Packet MKT-171).
- Notice by Qualified Beneficiaries of Social Security Disability Determination (MKT-56 / included in Election Packet MKT-171).
- Notice of Unavailability of COBRA Continuation Coverage (MKT-57).

It is important that you read the instructions to each of these sample forms before you use them. The instructions give you important information about how you may use them. For example, if Blue Cross and Blue Shield of Alabama does not handle the billing and collection of COBRA premiums for your plan, you must change these forms to fit your plan’s own COBRA procedures before you use them.

Additionally, if your plan is not insured by Blue Cross and Blue Shield of Alabama and your plan provides that “**legal separation**” is an event that will cause a spouse and/or dependent children to lose coverage under your plan, then you must revise these sample notices, where appropriate, to include “**legal separation**” as a qualifying event for COBRA purposes.

- If Blue Cross and Blue Shield of Alabama prepares your plan’s benefit booklet, we include the COBRA information in the benefit booklet.

- If your plan is fully-insured by Blue Cross and Blue Shield of Alabama, we include the COBRA information in your Group Administrator Manual.

What if Blue Cross and Blue Shield of Alabama handles the billing and collection of COBRA premiums for your plan?

In addition to the assistance above, if Blue Cross and Blue Shield of Alabama handles the billing and collection of COBRA premiums for your plan, we will do the following:

- Accept and process Notices by Qualified Beneficiaries of Social Security Disability Determinations and send to any ineligible person Notices of Unavailability of extended COBRA coverage for Social Security disability determinations. You must accept and process all other notices by qualified beneficiaries and notices of unavailability of COBRA coverage.

- Send Notices of Early Termination of COBRA Coverage, except if the early termination is the result of a termination of all your group health plans.

INSTRUCTIONS FOR GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Under COBRA, you must provide a General Notice of COBRA Continuation Coverage Rights to each covered employee and spouse within 90 days after the time their health plan coverage becomes effective. If the covered employee and the spouse enrolled in the health plan at the same time, you should send the General Notice addressed to the covered employee and spouse by first class mail with a certificate of mailing (or certified mail) to the employee's home address. If you are aware that the spouse resides elsewhere, you should send the spouse a separate notice to his or her address.

If Blue Cross and Blue Shield of Alabama handles the billing and collection of COBRA premiums for your health plan, you may use the sample General Notice of COBRA Continuation Coverage Rights to satisfy your COBRA general notice obligation. **You must fill in the blanks at the end of this notice with (i) the names of your group health plans covered by this notice and (ii) the name or position, address and telephone number of the plan administrator(s) of such plans.**

Blue Cross and Blue Shield of Alabama is not the plan administrator and is not the party that you will identify at the end of this notice. The plan administrator that you will identify at the end of this notice is the party from whom information about the plan and COBRA coverage can be obtained upon request and who will receive the notices of qualifying events described in this notice from covered employees and qualified beneficiaries.

REMINDER: Here are the COBRA documents you should deliver to a covered employee and spouse (in the manner described above) within 90 days after enrollment in your health plan.

- General Notice of COBRA Continuation Coverage Rights (MKT-116)

- Notice by Qualified Beneficiaries of Initial Qualifying Event (MKT-52)

The **General Notice of COBRA Continuation Coverage Rights (MKT-116) and the Notice by Qualified Beneficiaries of Initial Qualifying Event (MKT-52) are not included in the Blue Cross and Blue Shield of Alabama COBRA "Election Packet" (MKT-171). You will need to send each individual form to the covered employee and spouse within 90 days after enrollment in your health plan.**

If Blue Cross and Blue Shield of Alabama does not handle the billing and collection of COBRA premiums for your health plan, you must make other changes to the sample General Notice of COBRA Continuation Coverage Rights before you use it. For example, Blue Cross and Blue Shield of Alabama is not the party that you will name in your General Notice to receive notices by qualified beneficiaries of a Social Security Administration disability determination. You should consult your legal counsel to determine other changes to the sample General Notice that you should make.

COBRA

General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under one or more group health plans. The plan (or plans) under which you have become covered are listed at the end of this notice and are referred to collectively in this notice as "the plan." **This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For more information about your rights and obligations under the plan and under federal law, you should review the plan's summary plan description or contact the Plan Administrator for the plan. You will find the name, address and telephone number of the Plan Administrator at the end of this notice.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. However, you and your family members are not entitled to COBRA coverage if you are employed as a nonresident alien who received no U.S. source income. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

What are Qualifying Events for a Covered Employee?

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

What are Qualifying Events for a Covered Spouse?

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- You become divorced from your spouse.

If your spouse cancels your coverage under the plan in anticipation of divorce and a divorce later occurs, the divorce may be considered a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the Plan Administrator of the divorce and can establish that the covered employee canceled your coverage under the plan in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce). See the rules below under **"You Must Give Notice of Some Qualifying Events"** regarding your obligation to provide timely notice to the Plan Administrator and the procedures for doing so.

What are Qualifying Events for Covered Dependent Children?

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (under Part A, Part B, or both);
- The parents become divorced; or
- The child is no longer eligible for coverage under the plan as a "dependent child."

A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a qualified medical child support order is entitled to the same rights under COBRA as a dependent child of the covered employee. A child born to, adopted by or placed for adoption with a former employee during the period of COBRA coverage may also be a qualified beneficiary if the former employee is a qualified beneficiary who has elected COBRA coverage.

Additional Qualifying Event for Covered Retirees

If the plan provides retiree health coverage, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring the plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer if the plan provides retiree health coverage, or the employee's becoming enrolled in Medicare (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must timely notify the Plan Administrator in writing (using the procedures specified in the paragraph below entitled "Qualifying Event Notice Procedures") within 60 days after the qualifying event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage under the plan will not be offered the option to elect COBRA coverage as a result of these qualifying events.

Qualifying Event Notice Procedures: Any notice of a qualifying event that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail or hand deliver your notice to the Plan Administrator identified at the end of this notice. Your notice must be received by the Plan Administrator, identified at the end of this notice, no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies), and
- the qualifying event and the date of the qualifying event.

If the qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, we have provided a form of Notice by Qualified Beneficiaries of Initial Qualifying Event that you may use to notify the Plan Administrator of a qualifying event. You may also get a copy of this form, at no cost to you, from the Plan Administrator.

Other Notices You Must Give: You must also give notice of other events that are described later in this notice.
For example, please refer to the later paragraphs in this notice entitled **"Disability extension of 18-Month Period of Continuation Coverage" and "Second Qualifying Event Extension of 18-Month Period of Continuation Coverage"** for the notice procedures and notice time periods that apply to you in those circumstances.

How is COBRA Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage.

Duration of COBRA Coverage for Covered Employees

If you are the covered employee and the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your COBRA premiums on time. If, apart from COBRA, your employer continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are the covered employee and you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

Duration of COBRA Coverage for Covered Spouses and Dependent Children

If you are a covered spouse or dependent child and the qualifying event is the end of employment or reduction of the employee's hours, COBRA continuation coverage generally lasts for up to a total of 18 months from the date of termination of employment or reduction in hours, provided that COBRA premiums are paid on time. However, if the covered employee became enrolled in any part of Medicare before the end of his or her employment or reduction in hours, COBRA continuation for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last. For example, if a covered employee becomes enrolled in any part of Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event that is termination of employment (36 months minus 8 months).

If you are a covered spouse or dependent child and the qualifying event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months, provided that COBRA premiums are paid on time.

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator or its designee ***in writing***, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for this disability extension to apply, you must timely notify the Plan Administrator or its designee in writing (using the SSA Disability Notice procedures specified below) of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event, or (iii) the date of the SSA disability determination.

SSA Disability Notice Procedures: Any SSA disability notices that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand deliver your notice to:

Blue Cross and Blue Shield of Alabama
Attention: Customer Accounts
450 Riverchase Parkway East
Birmingham, AL 35244-2858
Fax: 205-220-6884 or 1-888-810-6884 (toll free)

Your notice must be received by Blue Cross and Blue Shield of Alabama no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event,
- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the SSA made its determination of disability.

Your notice must also include a copy of the SSA disability determination. For your convenience, we have prepared a form of Notice by Qualified Beneficiaries that you may use to notify Blue Cross and Blue Shield of Alabama of a SSA disability determination. You may get a copy of this form, at no cost to you, from either the Plan Administrator or Blue Cross and Blue Shield of Alabama. If these procedures are not followed or if the notice is not provided in writing to Blue Cross and Blue Shield of Alabama within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify Blue Cross and Blue Shield of Alabama within 30 days of any revocation of Social Security disability benefits.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if timely notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

For example, the former employee becoming enrolled in Medicare will rarely be a second qualifying event that would entitle the spouse or dependent children to extended COBRA coverage. This is so because, for plans that are subject to COBRA and the Medicare Secondary Payer (MSP) laws, this event would not cause the spouse or dependent children to lose coverage under the plan had the first qualifying event not occurred.

In order for this 18-month extension to apply, you must timely notify the Plan Administrator in writing (using the notice procedures specified in the above paragraph on which coverage would be lost because of the event, whichever is later. In addition, your notice must also name the second qualifying event and the date of the second qualifying event. For your convenience, we have prepared a form of Notice by Qualified Beneficiaries of Second Qualifying Event that you may use to notify the Plan Administrator of a second qualifying event. You may get a copy of this form, at no cost to you, from the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the required 60-day notice period, there will be no extension of COBRA coverage as a result of the second qualifying event.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.). For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator

Plan Administrator Contact Information

Group Health Plan(s) Covered by This Notice:

Plan Administrator: ________________________________

Name/Position: ________________________________

Address: ________________________________

Phone Number: ________________________________

INSTRUCTIONS TO NOTICE BY QUALIFIED BENEFICIARIES OF INITIAL QUALIFYING EVENT FORM

For the qualifying events of divorce or a dependent child losing eligibility for coverage as a dependent under the plan, the covered employee, spouse or dependent child must timely notify you (the Plan Administrator) in writing (using the procedures specified in the General Notice) within 60 days after the qualifying event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

As a convenience, a covered employee, spouse or dependent child may use this Notice by Qualified Beneficiaries of Initial Qualifying Event form to notify you of a divorce or a dependent child losing eligibility for coverage as a dependent under the plan.

If you use the sample General Notice that we have provided to you, you should deliver this Notice by Qualified Beneficiaries of Initial Qualifying Event form to the covered employee and spouse as an attachment to the General Notice. You should also give a copy of this form, at no cost, to the covered employee, spouse or dependent child upon request.

Before using this form, you must fill in the blanks for the Plan Administrator's name and address at the beginning of this form. This address should be the same address for the Plan Administrator that you used in the General Notice. Blue Cross and Blue Shield of Alabama is not the Plan Administrator.

REMINDER: Here are the COBRA documents you should deliver to a covered employee and spouse (in the manner described above) within 90 days after enrollment in your health plan.

- General Notice of COBRA Continuation Coverage Rights (MKT-116)

- Notice by Qualified Beneficiaries of Initial Qualifying Event (MKT-52)

The General Notice of COBRA Continuation Coverage Rights (MKT-116) and the Notice by Qualified Beneficiaries of Initial Qualifying Event (MKT-52) are not included in the Blue Cross and Blue Shield of Alabama COBRA "Election Packet" (MKT-171). You will need to send each individual form to the covered employee and spouse within 90 days after enrollment in your health plan.

COBRA

Notice by Qualified Beneficiaries of Initial Qualifying Event

IMPORTANT: If you are a qualified beneficiary and you lost or will lose coverage under one or more of our group health plans because of a qualifying event, you may be eligible for COBRA continuation coverage if you give the Plan Administrator timely notice of the qualifying event. To be timely, you must deliver this notice of a qualifying event to the Plan Administrator at:

Plan Administrator's Name	Address	City	State	Zip

within 60 days after the qualifying event or within 60 days after the date coverage is lost under the Plan because of the event, whichever is later. **If you do not deliver this notice by the due date above, you will lose your right to elect COBRA continuation coverage.** Please refer to the summary plan descriptions for your group health plan(s) for more information about COBRA continuation coverage.

Group Health Plan Information:

Please check the group health plans (the "Plan") under which you had coverage on the day before the qualifying event:

☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP

Qualified Beneficiary Information:

Please complete the information below for each person (spouse and dependent children) who lost or will lose coverage under the Plan because of the qualifying event.

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

Notice of Initial Qualifying Event:

Please check the event that occurred and give the date it occurred:

Event	DATE OF INITIAL QUALIFYING EVENT:
☐ DIVORCE OF THE EMPLOYEE AND SPOUSE* ☐ DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD *IF THE EVENT IS A DIVORCE, YOU MUST INCLUDE A COPY OF THE DIVORCE DECREE WITH THIS NOTICE.	MM/DD/YYYY

SIGNATURE PRINT NAME DATE

MKT-52 (10-2004)

INSTRUCTIONS TO COBRA CONTINUATION COVERAGE "ELECTION NOTICE"

Under COBRA, if an employee, spouse or dependent child lost or will lose health plan coverage due to a qualifying event (the "qualified beneficiaries") that is either **termination of employment, a reduction in hours, Medicare enrollment, or death**, you must send each qualified beneficiary a COBRA Continuation Coverage "Election Notice" within 44 days after such qualifying event. This "Election Notice" includes three documents — COBRA Continuation Coverage Election Letter (MKT-53), COBRA Continuation Coverage Election Form (MKT-365) and Important Information about your COBRA Continuation Coverage Rights (MKT-54). These three documents will be referred to as the "Election Notice" in the remainder of these instructions.

If the qualifying event is the employee's **divorce, or a dependent's loss of dependent status under the plan**, the employee, spouse or dependent child is required to notify you of such qualifying event. For more information about notices of qualifying events, please refer to the "Instructions to Notice by Qualified Beneficiaries of Initial Qualifying Event Form." Within 14 days of your receiving a notice of a qualifying event, you must send an "Election Notice" to the spouse and dependent children who lost or will lose health plan coverage under the plan due to the qualifying event (the "qualified beneficiaries").

You should send the "Election Notice" addressed to each qualified beneficiary by first class mail with a certificate of mailing (or certified mail) to the qualified beneficiaries' home address. If all of the qualified beneficiaries reside at the same address, you may send one "Election Notice" addressed to each of them (by name or status) at such address. If you are aware that a qualified beneficiary resides elsewhere, you should send such qualified beneficiary a separate "Election Notice" to his or her address.

If Blue Cross and Blue Shield of Alabama handles the billing and collection of COBRA premiums for your health plan, you may use the sample COBRA Continuation Coverage "Election Notice" to satisfy your COBRA election notice obligation. The "Election Notice" has three (3) parts:

- COBRA Continuation Coverage Election Letter (MKT-53) must contain detailed information about your health plans covered by the "Election Notice", the qualified beneficiaries covered by the "Election Notice" and the COBRA coverage offered by the "Election Notice". **You must fill in each of the blanks in this cover letter each time you send an "Election Notice".**

- COBRA Continuation Coverage Election Form (MKT-365). Except for the top portion of this election form, the qualified beneficiaries (or someone on their behalf) will fill in the blanks in this form to elect COBRA coverage and return the Election Form to you (the plan administrator). The qualified beneficiaries have 60 days from the later of (i) the date the qualified beneficiaries would lose coverage, or (ii) the date on which you notify the qualified beneficiaries of their COBRA election rights, to return this Election Form to you. **You must fill in the blanks in the top portion of this form.**

- A document entitled "Important Information About Your COBRA Continuation Coverage Rights (MKT-54)". **You must fill in the blanks at the end of this notice with the name or position, address and telephone number of the plan administrator(s) of such plans.** Blue Cross and Blue Shield of Alabama is not the plan administrator and is not the party that you will identify at the end of this notice. The plan administrator that you will identify at the end of this notice is the party from whom information about the plan and COBRA coverage can be obtained upon request and who will receive the notices of qualifying events described in this notice from qualified beneficiaries.

REMINDER: Here are the COBRA documents you should deliver to qualified beneficiaries upon the occurrence of a qualifying event (within the time periods and in the manner described above). These documents are included in the Blue Cross and Blue Shield of Alabama "Election Packet" (MKT-171) that you can order for this purpose. Before you send these documents, please remember to fill in the appropriate blanks with your information. If you use our " Election Packet" (MKT-171), you should mail it in an envelope with your return address so that any returned mail comes to you.

- COBRA Continuation Coverage "Election Notice" — This "Election Notice" includes COBRA Continuation Coverage Election Letter (MKT-53), COBRA Continuation Coverage Election Form (MKT-365) and Important Information about your COBRA Continuation Coverage Rights (MKT-54). The qualified beneficiaries should return the Election Form to you. You should keep the Election Form for your records.

- Notice by Qualified Beneficiaries of Second Qualifying Event (MKT-55/for future use if needed).

- Notice by Qualified Beneficiaries of SSA Disability Determination (MKT-56/for future use if needed).

- Continuation of Coverage Application (ENR-270 or ENR-421 for members enrolled in Alabama Personal Choice Network). The qualified beneficiaries should return the Application to you. If Blue Cross and Blue Shield of Alabama handles the COBRA billing for your group, you should forward the Application to us and keep a copy for your records.

If Blue Cross and Blue Shield of Alabama does **not** handle the billing and collection of COBRA premiums for your health plan, you must make other changes to the sample COBRA Continuation Coverage "Election Notice" before you use it. For example, Blue Cross and Blue Shield of Alabama is not the party that you will name in your "Election Notice" to receive notices by qualified beneficiaries of a Social Security Administration disability determination or to receive COBRA premium payments. You should consult your legal counsel to determine other changes to the sample "Election Notice" that you should make.

COBRA | COBRA Continuation Coverage Election Letter

Date of Notice:	MM/DD/YYYY
To:	NAME OF EMPLOYEE, SPOUSE, DEPENDENT CHILDREN, AS APPROPRIATE
Address:	ADDRESS TO WHICH NOTICE IS BEING SENT

This notice has important information about your right to continue your healthcare coverage with your group health plan(s), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision.

To elect COBRA continuation coverage, follow the instructions to complete the Election Form (MKT-365) and submit it to the Plan Administrator at the address below. This Election Form should be included in your COBRA Election Packet (MKT-171). Federal law requires that most group health plans (including this plan) give employees and their families the opportunity to continue their healthcare coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

COBRA continuation coverage is the same coverage that the plan gives to other plan members who aren't getting continuation coverage.
Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other members covered under the plan.

If you do not elect COBRA continuation coverage, your coverage under the plan will end on	MM/DD/YYYY
Please check the reason below: ☐ **End of employment** ☐ **Reduction in hours of employment** ☐ **Death of employee** ☐ **Divorce** ☐ **Enrollment in Medicare** ☐ **Loss of dependent child status**	Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group healthcare coverage under the plan for up to __________ months. If you elect COBRA continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event within a certain time period to extend the period of COBRA continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of COBRA continuation coverage. For more information about extending the length of COBRA continuation coverage visit www.dol.gov/ebsa/publications/cobraemployee.html.

Please check the appropriate box or boxes below and give the names:

☐ Covered employee or covered former employee		☐ Covered spouse or covered former spouse	
☐ Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage		☐ Child who is losing coverage under the plan because he or she is no longer a dependent under the plan	

If any of the persons listed above do not reside at the address to which this notice was sent, please notify the Plan Administrator of the new address for these persons so that we may give them a copy of this notice.

If elected, COBRA continuation coverage will begin on	MM/DD/YYYY	**and can last until**	MM/DD/YYYY

COBRA continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

You may elect either family coverage or single coverage for COBRA continuation coverage.

COBRA continuation coverage cost	**Family:**	**Single:**

Other coverage options may cost less. Your cost for COBRA coverage may change over time, as the cost of benefits under the plan changes.
You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in "Important Information about your COBRA Continuation Coverage Rights" (MKT-54).

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.
You can learn more about the Marketplace on the back of this page.

MKT-53 (Rev. 7-2014)

OVER ⟶

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period.You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

Premiums:	Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
Provider Networks:	If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
Drug Formularies:	If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
Severance payments:	If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
Service Areas:	Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
Other Cost-Sharing:	In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If you have any questions about your rights to COBRA continuation coverage, you should contact:

Plan Administrator:	Name/Position:
Address:	Phone Number:

MKT-53 (Rev. 7-2014)

C O B R A

Cobra Continuation Coverage Election Form

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: ______________________________

____

____

This Election Form must be completed and returned by mail or hand delivery on ______________________.

If mailed, it must be post-marked no later than ______________________.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date that your group health plan coverage terminated.

READ THE IMPORTANT INFORMATION PROVIDED ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS (included in COBRA Election packet MKT-171)

I (We) elect **COBRA** continuation coverage in the following group health plans (the plan) as indicated below:

Type of plans (please check): ☐ **Health** ☐ **Dental**

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
DATE OF BIRTH MM/DD/YYYY		RELATIONSHIP TO EMPLOYEE	

Type of coverage elected (please check one only):

☐ I (We) elect to continue family coverage under the plan

☐ I (We) elect to continue single coverage under the plan

☐ I decline/waive my right to COBRA continuation coverage under the plan

SIGNATURE PRINT NAME DATE

PRINT ADDRESS TELEPHONE NUMBER

RELATIONSHIP TO EMPLOYEE

MKT-365 (Rev. 1-2009)

COBRA

Important Information About Your COBRA Continuation Coverage Rights

What is COBRA continuation coverage?

A federal law known as COBRA requires that most group health plans (including the plan or plans that are listed in the COBRA Continuation Coverage Election Form and collectively referred to in this notice as "the plan") give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under the plan. Only persons known as "qualified beneficiaries" may elect to continue their coverage under the plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a qualified medical child support order is entitled to the same rights under COBRA as a dependent child of the covered employee. A child born to, adopted by or placed for adoption with a former employee during the period of COBRA coverage may also be a qualified beneficiary if the former employee is a qualified beneficiary who has elected COBRA coverage. Continuation coverage is the same coverage that the plan gives to other participants or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights and any open enrollment rights.

How long will COBRA continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce, the employee's becoming enrolled in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became enrolled in Medicare before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare enrollment or 18 months after the date of termination of employment or reduction in hours, whichever period ends last. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Can COBRA coverage terminate early?

Continuation coverage will be terminated **before** the end of the maximum period if:

- any required premium is not paid in full on time,
- after electing continuation coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, (note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusion will become prohibited beginning in 2014 under the Affordable Care Act)
- after electing continuation coverage, a qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both),
- a qualified beneficiary is covered under the additional 11-month disability extension and there has been a final determination by the Social Security Administration that the disabled qualified individual is no longer disabled, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum 18-month period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must timely notify the Plan Administrator or his designee of a disability or a second qualifying event, using the notice procedures specified below, in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage (for a maximum of 29 months of coverage) may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for this disability extension to apply, you must timely notify the Plan Administrator or its designee in writing (using the notice procedures specified below) of the SSA disability determination before the end of the 18-month period of continuation coverage **and** within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage would be lost because of the initial qualifying event, or (iii) the date of the SSA disability determination.

SSA Disability Notice Procedures: The SSA disability notices that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand deliver your notice to:

Blue Cross and Blue Shield of Alabama
Attention: Customer Accounts
450 Riverchase Parkway East
Birmingham, AL 35298-0001
Fax: (205) 220-6884 or 1 888 810-6884 (toll free)

Your notice must be received by Blue Cross and Blue Shield of Alabama no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event,
- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the SSA made its determination of disability.

Your notice must also include a copy of the SSA disability determination. For your convenience, we have provided a form of Notice by Qualified Beneficiaries that you may use to notify Blue Cross and Blue Shield of Alabama of a SSA disability determination. You may also get a copy of this form, at no cost to you, from either the Plan Administrator or Blue Cross and Blue Shield of Alabama. If these procedures are not followed or if the notice is not provided in writing to Blue Cross and Blue Shield of Alabama within the required time period, there will be no disability extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Blue Cross and Blue Shield of Alabama of that fact within 30 days after SSA's determination.

Second Qualifying Event
An extension of coverage for up to 18 months will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage.The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months (beginning on the date of the first qualifying event). Such second qualifying events may include the death of a covered employee, divorce from the covered employee, the covered employee's becoming enrolled in Medicare (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred.

For example, the former employee becoming enrolled in Medicare will rarely be a second qualifying event that would entitle the spouse or dependent children to extended COBRA coverage. This is so because, for plans that are subject to both COBRA and the Medicare Secondary Payer (MSP) laws, this event would not cause the spouse or dependent children to lose coverage under the plan had the first qualifying event not occurred.

In order for this extension to apply, you must timely notify the Plan Administrator in writing (using the procedures specified below) of the second qualifying event within 60 days after the second qualifying event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

Qualifying Event Notice Procedures: The notice of the second qualifying event that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or hand deliver your notice to the Plan Administrator at the address listed at the end of this notice. Your notice must be received by the Plan Administrator no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day period. The notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the qualified beneficiary(ies),
- the qualifying event and the date of the qualifying event, and
- the second qualifying event and the date of the second qualifying event.

If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, we have provided a form of Notice by Qualified Beneficiaries that you may use to notify the Plan Administrator of a second qualifying event. You may also get a copy of this form, at no cost to you, from the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA coverage as a result of the second qualifying event.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Failure to do so will result in the loss of the right to elect COBRA continuation coverage. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

In the case of an extension of COBRA coverage due to disability, the amount a qualified beneficiary may be required to pay may not exceed 150 percent of the full cost to the plan after the 18th month, assuming that the disabled qualified beneficiary elects to be covered under the disability extension. If the only qualified beneficiaries who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102 percent of the full cost of coverage.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the plan. Your first payment for continuation coverage must include all premiums owed from the date on which COBRA coverage began. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA Continuation Coverage Election Letter. The periodic payments can be made on a monthly basis.

Under the plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the plan will continue for that coverage period without any break. You will receive periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

Blue Cross and Blue Shield of Alabama
Attention: COBRA
P.O. Box 361346
Birmingham, AL 35236-1346

For more information

This notice does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact the Plan Administrator below.

For more information about your rights under ERISA,including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Contact Information

Plan Administrator: ______________________________

Name/Position: ______________________________

Address: ______________________________

Phone Number: ______________________________

Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

COBRA

CONTINUATION OF COVERAGE APPLICATION

BlueCross BlueShield
of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001
(205) 988-2200

ENR-270 (Rev. 6-2013)

COBRA CONTINUATION OF COVERAGE APPLICATION

FOR OFFICE USE ONLY

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended.

EMPLOYEE INFORMATION

PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK BALL POINT PEN - PRESS FIRMLY)

*** INDICATES REQUIRED FIELDS**

○ DR. ○ MR. ○ MRS. ○ MS.

HEALTH GRP. NO. * | HEALTH DIV. NO. | HEALTH CONTRACT NUMBER *

DENTAL GRP. NO. * | DENTAL DIV. NO. | DENTAL CONTRACT NUMBER *

LAST NAME * | FIRST NAME *

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | SOCIAL SECURITY NUMBER * ___ - __ - ____

ADDRESS ☐ BILLING ☐ MAILING

CITY | STATE | ZIP

DATE OF BIRTH (MM/DD/YYYY) * __ / __ / ____

PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL (___) ___ - ____

☐ MALE ☐ FEMALE

E-MAIL ADDRESS (Optional)

COBRA APPLICANT INFORMATION

(If different from above)

LAST NAME * | FIRST NAME *

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | SOCIAL SECURITY NUMBER * ___ - __ - ____

ADDRESS ☐ BILLING ☐ MAILING

CITY | STATE | ZIP

DATE OF BIRTH (MM/DD/YYYY) * __ / __ / ____

PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL (___) ___ - ____

☐ MALE ☐ FEMALE

E-MAIL ADDRESS (Optional)

REASON I CAN CONTINUE COVERAGE

(Check one)

○ Death ○ Divorce ○ Legal Separation (when applicable)

○ No Longer An Eligible Dependent ○ Termination/Reduction in Hours

○ Employee is entitled to Medicare (when applicable)

DATE EVENT OCCURRED (MM/DD/YYYY) * __ / __ / ____

COORDINATION OF BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by any other group health insurance, please give the following information.

NAME OF CONTRACT HOLDER	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY	GROUP NUMBER

EMPLOYER'S NAME	NAME OF INSURANCE COMPANY

MEDICARE BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by Medicare, please give the following information.

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

○ PART A (MM/DD/YYYY EFFECTIVE DATE) / /

○ PART B (MM/DD/YYYY EFFECTIVE DATE) / /

○ PART D (MM/DD/YYYY EFFECTIVE DATE) / /

LIST ELIGIBLE DEPENDENTS TO BE SHOWN ON THE CONTINUATION COVERAGE AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of your Group Plan.

LAST NAME

FIRST NAME *

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER * - -

RELATIONSHIP ○ SPOUSE ○ OTHER ____________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ____________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ____________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ____________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

TRANSFER COVERAGE — A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

MEDICARE BENEFITS INFORMATION *If you, your spouse, or your dependents are covered by Medicare, please give the following information.*

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

PART A (MM/DD/YYYY EFFECTIVE DATE) / /

PART B (MM/DD/YYYY EFFECTIVE DATE) / /

PART D (MM/DD/YYYY EFFECTIVE DATE) / /

LIST ELIGIBLE DEPENDENTS TO BE SHOWN ON THE CONTINUATION COVERAGE AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of your Group Plan.

LAST NAME

FIRST NAME *

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER * - -

RELATIONSHIP ○ SPOUSE ○ OTHER ________________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ________________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ________________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER - -

RELATIONSHIP ○ CHILD ○ OTHER ________________________

GENDER ○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

TRANSFER COVERAGE — A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

- ○ I acknowledge that I have received and read a COBRA notice informing me of my COBRA rights.
- ○ I understand and acknowledge that it is the Employer's obligation (and not Blue Cross') to provide me with any and all continuation coverage to which I might be entitled under COBRA or under the provisions of the Employer's group health plan implementing COBRA. I further understand and acknowledge that my COBRA benefits are provided to me under and in accordance with the provisions of Part 6 of Title I of the Employee Retirement Income Security Act of 1974. In the event of a dispute between me and Blue Cross regarding my benefits under COBRA or under this application, I understand that any administrative remedies available under the Employer's group plan must be used and exhausted by me before bringing any action against Blue Cross, notwithstanding cancellation of the Employer's coverage.

By signing below, I agree to pay to Blue Cross and Blue Shield of Alabama the monthly premium to continue the group benefits for me and my eligible dependents, if any, who are listed above. I can continue COBRA coverage for 18 months following my termination of employment or reduction in hours or 36 months if my coverage was terminated for any other event listed above. Under certain circumstances explained in the COBRA notice, if I or a member of my family is or becomes disabled during the first 60 days of COBRA coverage, the 18 month period may be extended to 29 months.

I understand the first payment is due by 45 days after I first elected COBRA. The first payment must include all premiums retroactive to the effective date of my COBRA coverage. All other payments are due within 30 days of the due date. If I fail to pay the amount due on time or if I request that my coverage be cancelled, my coverage will end and not be reinstated under any circumstances.

I understand that coverage will end for me or any of my dependents who become covered by Medicare or any other group health coverage which does not have limitations or exclusions for pre-existing conditions or which has them but they do not apply.
I will notify you in writing if I become covered by another group plan or Medicare. If I or any of my qualified dependents become disabled according to the Social Security Administration (SSA), I will notify you in writing before the end of the 18 month period and within 60 days after the later of the date of my initial qualifying date, the date on which my coverage is lost under my group health plan because of such event, or the date of the SSA disability determination.

While I continue the benefits provided by this group, these benefits are subject to all terms and conditions of the Employer's group health plan and any agreement between the Employer and Blue Cross and Blue Shield of Alabama. My benefits and/or rates will change when this Employer's benefits change, and will end if the Employer's coverage is cancelled at the same time benefits for active employees of the Employer end, regardless of whether I have continued to pay for my coverage.

I wish to continue the following coverage:

- ○ **HEALTH ONLY**
- ○ **HEALTH AND DENTAL**
- ○ **DENTAL ONLY**

○ *Enclosed with the application is a check or money order for the premium payment to cover the period from the effective date of my COBRA Coverage through the current coverage period.*

SIGNATURE OF APPLICANT * ______________________________

PRINT APPLICANT NAME ______________________________

APPLICANT'S SOCIAL SECURITY NUMBER *
☐☐☐ - ☐☐ - ☐☐☐☐

DATE SIGNED ______________________________

TO BE COMPLETED BY EMPLOYER

I am authorized by the Employer named below to certify that the person named above is eligible under COBRA to continue group health plan coverage to be effective for a maximum of __________ (18 or 36) months. The monthly rate for the continuation coverage will be $ ________._____ per month until notified by Blue Cross and Blue Shield of Alabama under the conditions noted above.

EMPLOYER NAME
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMPLOYER PHONE NUMBER
(☐☐☐) ☐☐☐ - ☐☐☐☐

EXTENSION
☐☐☐☐

COBRA EFFECTIVE DATE (MM/DD/YYYY) *
☐☐ / ☐☐ / ☐☐☐☐

DATE OF TERMINATION/LAYOFF (MM/DD/YYYY) (If Applicable) *
☐☐ / ☐☐ / ☐☐☐☐

SIGNATURE OF AUTHORIZED REPRESENTATIVE * ______________________________

PRINTED AUTHORIZED REPRESENTATIVE NAME ______________________________

DATE SIGNED ____________________

ENR-270 (Rev. 6-2013)

BLUE CROSS AND BLUE SHIELD COPY
TOP COPY

EMPLOYER COPY
MIDDLE COPY

EMPLOYEE COPY
BOTTOM COPY

Important Information About Your COBRA Premiums

Blue Cross and Blue Shield of Alabama administers benefits for COBRA subscribers so long as their former employer maintains coverage by our company. This information is provided to inform you of important information as it relates to the administration of your COBRA coverage. The information is general because the COBRA law and regulations are complex. If you have a question about your eligibility for COBRA coverage, please call your group. If you have a question about payment for COBRA coverage after you are enrolled in COBRA, please call our Customer Service Department at 1 800 292-8868.

BILLING

1. Please send your payment to Blue Cross promptly. Under COBRA regulations, Blue Cross will cancel your coverage when payment is not received within 30 days of the due date which appears on your bill. The only exception to the 30 day rule is the first payment due. You will have 45 days from election of COBRA to make the first payment. The first payment must include all premiums due since the effective date of your COBRA coverage. After the first payment, you will receive monthly invoice statements showing the monthly COBRA premium amount due. If the monthly COBRA premium amount shown to be due on the invoice statement does not match the monthly COBRA premium amount you received from your group, please call our Customer Service Department at 1 800 292-8868. If your coverage is cancelled because payment has not been received within the appropriate time frame, Blue Cross will not reinstate your COBRA coverage.

2. Each year rates for your group may increase. If this happens, your COBRA rates will also increase. Depending on when Blue Cross is notified and any new benefit issues are settled to establish new rates, you may be retroactively billed the rate increase.

3. If your check is returned to Blue Cross due to insufficient funds and we do not receive payment in full within 30 days of the due date which appears on your bill, your contract will be cancelled and will not be reinstated. If your check is returned to Blue Cross due to insufficient funds after 30 days of the due date, your contract will be cancelled and will not be reinstated.

4. If your former employer's coverage is cancelled with Blue Cross, then your COBRA coverage through Blue Cross is also cancelled. Likewise, if your former employer changes coverage to another carrier then your COBRA coverage by Blue Cross will be cancelled. You will be referred to your group for information on COBRA coverage by your new carrier.

PAYMENT PROCESSING

Your health is important to us and we want to make sure you continue receiving the best coverage available. Here are four simple steps you can take to ensure continuous coverage while you are enrolled under your COBRA coverage:

1. Pay the exact amount due by the due date. Your payment is considered past due by the delinquent date.

2. If you do not receive a statement by the first of the month, please call our Customer Service Department at 1 800 292-8868 to arrange payment.

3. Always write your contract number(s) on your check.

4. If you have health and dental coverage, return both statements with a separate check for each coverage. Remember to put your contract number(s) on both checks.

CHANGES TO YOUR COBRA COVERAGE

Any eligibility changes due to your COBRA coverage will be in accordance with the guidelines established by your group and must be reported to Blue Cross promptly.

1. To change your COBRA coverage from family to individual, your spouse must write us a letter that includes his or her signature, requesting to be removed from your COBRA coverage. If your spouse is being removed from your COBRA coverage because of a divorce or legal separation, the spouse may be eligible for an extension of COBRA coverage. Please refer to the COBRA Continuation Coverage Election Notice for more information about how to qualify for an extension of COBRA coverage in this case.

2. Address changes must be reported to us immediately by phone or letter.

3. Notify us if you become covered by any other group coverage or by Medicare.

PLEASE DETACH AND RETAIN THIS PAGE

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

COBRA

CONTINUATION OF COVERAGE APPLICATION

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001
(205) 988-2200

ALABAMA Personal Choice℠

ALABAMA Personal Choice™

COBRA CONTINUATION OF COVERAGE APPLICATION

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended.

FOR OFFICE USE ONLY

EMPLOYEE INFORMATION

PLEASE PRINT USING UPPERCASE LETTERS:
(USE BLACK BALL POINT PEN - PRESS FIRMLY)

*** INDICATES REQUIRED FIELDS**

○ DR. ○ MR. ○ MRS. ○ MS.

HEALTH GRP. NO. * | HEALTH DIV. NO. | HEALTH CONTRACT NUMBER *

DENTAL GRP. NO. * | DENTAL DIV. NO. | DENTAL CONTRACT NUMBER *

LAST NAME * | FIRST NAME *

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | SOCIAL SECURITY NUMBER * ___-__-____ | ☐ MALE ☐ FEMALE

ADDRESS ☐ BILLING ☐ MAILING

CITY | STATE | ZIP

DATE OF BIRTH (MM/DD/YYYY) * __/__/____ | PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL ( ) - | E-MAIL ADDRESS (Optional)

PRIMARY CARE PHYSICIAN NAME | PHYSICIAN NPI

COBRA APPLICANT INFORMATION

(If different from above)

LAST NAME * | FIRST NAME *

MAIDEN/MIDDLE NAME | SUFFIX (JUNIOR, SENIOR) | SOCIAL SECURITY NUMBER * ___-__-____ | ☐ MALE ☐ FEMALE

ADDRESS ☐ BILLING ☐ MAILING

CITY | STATE | ZIP

DATE OF BIRTH (MM/DD/YYYY) * __/__/____ | PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL ( ) - | E-MAIL ADDRESS (Optional)

PRIMARY CARE PHYSICIAN NAME | PHYSICIAN NPI

REASON I CAN CONTINUE COVERAGE

(Check one)

○ Death ○ Divorce ○ Legal Separation *(When Applicable)* ○ Dependent Married

○ No Longer An Eligible Dependent ○ Termination/Reduction in Hours

○ Employee is entitled to Medicare *(When Applicable)*

DATE EVENT OCCURRED (MM/DD/YYYY) * __/__/____

COORDINATION OF BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by any other group health insurance, please give the following information.

NAME OF CONTRACT HOLDER	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY	GROUP NUMBER

EMPLOYER'S NAME	NAME OF INSURANCE COMPANY

COBRA APPLICANT NAME

LAST NAME *

FIRST NAME *

SOCIAL SECURITY NUMBER *

MEDICARE BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by Medicare, please give the following information.

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

PART A (MM/DD/YYYY EFFECTIVE DATE) / /

PART B (MM/DD/YYYY EFFECTIVE DATE) / /

PART D (MM/DD/YYYY EFFECTIVE DATE) / /

LIST ELIGIBLE DEPENDENTS TO BE SHOWN ON THE CONTINUATION COVERAGE AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of your Group Plan.

LAST NAME *

FIRST NAME *

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER *

RELATIONSHIP
○ SPOUSE ○ OTHER ______________________

GENDER
○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

PRIMARY CARE PHYSICIAN NAME

PHYSICIAN NPI

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER

RELATIONSHIP
○ CHILD ○ OTHER ______________________

GENDER
○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

PRIMARY CARE PHYSICIAN NAME

PHYSICIAN NPI

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER

RELATIONSHIP
○ CHILD ○ OTHER ______________________

GENDER
○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY) / /

PRIMARY CARE PHYSICIAN NAME

PHYSICIAN NPI

TRANSFER COVERAGE — A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

○ I acknowledge that I have received and read a COBRA notice informing me of my COBRA rights.

○ I understand and acknowledge that it is the Employer's obligation (and not Blue Cross') to provide me with any and all continuation coverage to which I might be entitled under COBRA or under the provisions of the Employer's group health plan implementing COBRA. I further understand and acknowledge that my COBRA benefits are provided to me under and in accordance with the provisions of Part 6 of Title I of the Employee Retirement Income Security Act of 1974. In the event of a dispute between me and Blue Cross regarding my benefits under COBRA or under this application, I understand that any administrative remedies available under the Employer's group plan must be used and exhausted by me before bringing any action against Blue Cross, notwithstanding cancellation of the Employer's coverage.

By signing below, I agree to pay to Blue Cross and Blue Shield of Alabama the monthly premium to continue the group benefits for me and my eligible dependents, if any, who are listed above. I can continue COBRA coverage for 18 months following my termination of employment or reduction in hours or 36 months if my coverage was terminated for any other event listed above. Under certain circumstances explained in the COBRA notice, if I or a member of my family is or becomes disabled during the first 60 days of COBRA coverage, the 18 month period may be extended to 29 months.

I understand the first payment is due by 45 days after I first elected COBRA. The first payment must include all premiums retroactive to the effective date of my COBRA coverage. All other payments are due within 30 days of the due date. If I fail to pay the amount due on time or if I request that my coverage be cancelled, my coverage will end and not be reinstated under any circumstances.

I understand that coverage will end for me or any of my dependents who become covered by Medicare or any other group health coverage which does not have limitations or exclusions for pre-existing conditions or which has them but they do not apply.
I will notify you in writing if I become covered by another group plan or Medicare. If I or any of my qualified dependents become disabled according to the Social Security Administration (SSA),

I will notify you in writing before the end of the 18 month period and within 60 days after the date of my initial qualifying date, the date on which my coverage is lost under my group health plan because of such event, or the date of the SSA disability determination.

While I continue the benefits provided by this group, these benefits are subject to all terms and conditions of the Employer's group health plan and any agreement between the Employer and Blue Cross and Blue Shield of Alabama. My benefits and/or rates will change when this Employer's benefits change, and will end if the Employer's coverage is cancelled at the same time benefits for active employees of the Employer end, regardless of whether I have continued to pay for my coverage.

I wish to continue the following coverage:

○ **HEALTH ONLY**
○ **HEALTH AND DENTAL**
○ **DENTAL ONLY**

○ *Enclosed with the application is a check or money order for the premium payment to cover the period from the effective date of my COBRA Coverage through the current coverage period.*

SIGNATURE OF APPLICANT * ______________________________

PRINT APPLICANT NAME ______________________________

APPLICANT'S SOCIAL SECURITY NUMBER *
☐☐☐ – ☐☐ – ☐☐☐☐

DATE SIGNED ______________________________

TO BE COMPLETED BY EMPLOYER

I am authorized by the Employer named below to certify that the person named above is eligible under COBRA to continue group health plan coverage to be effective for a maximum of __________ (18 or 36) months. The monthly rate for the continuation coverage will be $ ________._____ per month until notified by Blue Cross and Blue Shield of Alabama under the conditions noted above.

EMPLOYER NAME
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMPLOYER PHONE NUMBER
(☐☐☐) ☐☐☐ - ☐☐☐☐

EXTENSION
☐☐☐☐

COBRA EFFECTIVE DATE (MM/DD/YYYY) *
☐☐ / ☐☐ / ☐☐☐☐

DATE OF TERMINATION/LAYOFF (MM/DD/YYYY) (If Applicable) *
☐☐ / ☐☐ / ☐☐☐☐

SIGNATURE OF AUTHORIZED REPRESENTATIVE * ______________________________

PRINT AUTHORIZED REPRESENTATIVE NAME ______________________________

DATE SIGNED ____________________

ENR-421 (Rev. 6-2013) BLUE CROSS AND BLUE SHIELD COPY SUBSCRIBER COPY EMPLOYEE COPY

Important Information About Your COBRA Premiums

Blue Cross and Blue Shield of Alabama administers benefits for COBRA subscribers so long as their former employer maintains coverage by our company. This information is provided to inform you of important information as it relates to the administration of your COBRA coverage. The information is general because the COBRA law and regulations are complex. If you have a question about your eligibility for COBRA coverage, please call your group. If you have a question about payment for COBRA coverage after you are enrolled in COBRA, please call our Customer Service Department at 1 800 292-8868.

BILLING

1. Please send your payment to Blue Cross promptly. Under COBRA regulations, Blue Cross will cancel your coverage when payment is not received within 30 days of the due date which appears on your bill. The only exception to the 30 day rule is the first payment due. You will have 45 days from election of COBRA to make the first payment. The first payment must include all premiums due since the effective date of your COBRA coverage. After the first payment, you will receive monthly invoice statements showing the monthly COBRA premium amount due. If the monthly COBRA premium amount shown to be due on the invoice statement does not match the monthly COBRA premium amount you received from your group, please call our Customer Service Department at 1 800 292-8868. If your coverage is cancelled because payment has not been received within the appropriate time frame, Blue Cross will not reinstate your COBRA coverage.

2. Each year rates for your group may increase. If this happens, your COBRA rates will also increase. Depending on when Blue Cross is notified and any new benefit issues are settled to establish new rates, you may be retroactively billed the rate increase.

3. If your check is returned to Blue Cross due to insufficient funds and we do not receive payment in full within 30 days of the due date which appears on your bill, your contract will be cancelled and will not be reinstated. If your check is returned to Blue Cross due to insufficient funds after 30 days of the due date, your contract will be cancelled and will not be reinstated.

4. If your former employer's coverage is cancelled with Blue Cross, then your COBRA coverage through Blue Cross is also cancelled. Likewise, if your former employer changes coverage to another carrier then your COBRA coverage by Blue Cross will be cancelled. You will be referred to your group for information on COBRA coverage by your new carrier.

PAYMENT PROCESSING

Your health is important to us and we want to make sure you continue receiving the best coverage available. Here are four simple steps you can take to ensure continuous coverage while you are enrolled under your COBRA coverage:

1. Pay the exact amount due by the due date. Your payment is considered past due by the delinquent date.

2. If you do not receive a statement by the first of the month, please call our Customer Service Department at 1 800 292-8868 to arrange payment.

3. Always write your contract number(s) on your check.

4. If you have health and dental coverage, return both statements with a separate check for each coverage. Remember to put your contract number(s) on both checks.

CHANGES TO YOUR COBRA COVERAGE

Any eligibility changes due to your COBRA coverage will be in accordance with the guidelines established by your group and must be reported to Blue Cross promptly.

1. To change your COBRA coverage from family to individual, your spouse must write us a letter that includes his or her signature, requesting to be removed from your COBRA coverage. If your spouse is being removed from your COBRA coverage because of a divorce or legal separation, the spouse may be eligible for an extension of COBRA coverage. Please refer to the COBRA Continuation Coverage Election Notice for more information about how to qualify for an extension of COBRA coverage in this case.

2. Address changes must be reported to us immediately by phone or letter.

3. Notify us if you become covered by any other group coverage or by Medicare.

PLEASE DETACH AND RETAIN THIS PAGE

Instructions for Notice by Qualified Beneficiaries of Second Qualifying Event Form

An extension of COBRA coverage for up to 36 months (from the date of the first qualifying event) may be available to spouses and dependent children who elect COBRA(the "qualified beneficiaries") if a second qualifying event occurs during the first 18 months of COBRA coverage. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. For this extension to apply, qualified beneficiaries (or someone on their behalf) must timely notify you (the plan administrator) in writing (using the procedures specified in the General Notice) within 60 days after the second qualifying event occurs or within 60 days after the date coverage is lost, whichever is later.

As a convenience, qualified beneficiaries may use this Notice by Qualified Beneficiaries of a Second Qualifying Eventform to notify you of a second qualifying event. If you use the sample Election Notice that we have provided to you, you should deliver this Notice By Qualified Beneficiaries form to the qualified beneficiaries as an attachment to the Election Notice. You should also give a copy of this form, at no cost, to qualified beneficiaries upon request.

Before using this form, you must fill in the blanks for the plan administrator's address at the beginning of this form. This address should be the same address for the plan administrator that you used in the General Notice and Election Notice. Blue Cross and Blue Shield of Alabama is not the plan administrator.

REMINDER: Here are the COBRA documents you should deliver to qualified beneficiaries upon the occurrences of qualifying events (within the time periods and in the manner described above). These documents are included in the Blue Cross and Blue Shield of Alabama "Election Packet" (MKT-171) that you can order for this purpose. Before you send these documents, please remember to fill in the appropriate blanks with your information. If you use our " Election Packet" (MKT-171), you should mail it in an envelope with your return address so that anyreturned mail comes to you.

- COBRA Continuation Coverage "Election Notice" — This "Election Notice" includes COBRA Continuation Coverage Election Letter (MKT-53), COBRA Continuation Coverage Election Form (MKT-365) and Important Information about your COBRA Continuation Coverage Rights (MKT-54). The qualified beneficiaries should return the Election Form to you. You should keep the Election Form for your records.

- Notice by Qualified Beneficiaries of Second Qualifying Event (MKT-55/for future use if needed).

- Notice by Qualified Beneficiaries of SSADisability Determination (MKT-56/for future use if needed).

- Continuation of Coverage Application (ENR-270 or ENR-421 for members enrolled in Alabama Personal Choice Network). The qualified beneficiaries should return the Application to you. If Blue Cross and Blue Shield of Alabama handles the COBRA billing for your group, you should forward the Application to us and keep a copy for your records.

C O B R A

Notice by Qualified Beneficiaries of Second Qualifying Event

IMPORTANT: An extension of COBRA coverage for up to 36 months (from the date of the first qualifying event) may be available to spouses and dependent children who elect COBRA if a second qualifying event occurs during the first 18 months of COBRA coverage. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. For this extension to apply, you must deliver this notice to us at:

Plan Administrator's Name	Address	City	State	Zip

within 60 days after the second qualifying event or within 60 days after the date coverage is lost under the Plan because of the event, whichever is later. **If you do not deliver this notice by the due date above, you will lose your right to an extension of COBRA continuation coverage.** Please refer to the summary plan descriptions for your group health plan(s) for more information about COBRA continuation coverage.

Group Health Plan Information:

Please check the group health plans (the "Plan") under which you have COBRA coverage: ☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP
DATE OF TERMINATION/REDUCTION IN HOURS MM/DD/YYYY			

Qualified Beneficiary Information:

Please complete the information below for each person (any spouse or dependent children) who has COBRA coverage:

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE			

Notice of Second Qualifying Event:

Please check the event that occurred and give the date it occurred:

	DATE OF SECOND QUALIFYING EVENT:
☐ DIVORCE OF THE EMPLOYEE AND SPOUSE* ☐ DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD ☐ DEATH OF EMPLOYEE *IF THE EVENT IS A DIVORCE, YOU MUST INCLUDE A COPY OF THE DIVORCE DECREE WITH THIS NOTICE.	MM/DD/YYYY

SIGNATURE	PRINT NAME	DATE

MKT-55 (Rev.1-2009)

Instructions for Notice by Qualified Beneficiaries of SSA Disability Determination

COBRA coverage may be extended for up to 29 months (from the date of the first qualifying event) if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and must last until the end of the 18-month COBRA coverage period. For this extension to apply, qualified beneficiaries (or someone on their behalf) must timely notify the plan administrator or its designee in writing (using the procedures specified in the General Notice) of a SSA disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage is lost under the plan because of the initial qualifying event, or (iii) the date of the SSA disability determination.

If Blue Cross and Blue Shield of Alabama handles the billing and collection of COBRA premiums for your plan, Blue Cross and Blue Shield of Alabama will accept and process notices of SSA disability determinations on behalf of your plan. As a convenience, qualified beneficiaries may use this Notice by Qualified Beneficiaries of SSA Disability Determination form to notify us of an SSA disability determination.

If you use the sample Election Notice that we have provided to you, you should deliver this Notice By Qualified Beneficiaries form to the qualified beneficiaries as an attachment to the Election Notice. You should also give a copy of this form, at no cost, to qualified beneficiaries upon request. Qualified beneficiaries may also get a copy of this form, at no cost, from Blue Cross and Blue Shield of Alabama.

REMINDER: Here are the COBRA documents you should deliver to qualified beneficiaries upon the occurrences of qualifying events (within the time periods and in the manner described above). These documents are included in the Blue Cross and Blue Shield of Alabama “Election Packet” (MKT-171) that you can order for this purpose. Before you send these documents, please remember to fill in the appropriate blanks with your information. If you use our “ Election Packet” (MKT-171), you should mail it in an envelope with your return address so that any returned mail comes to you.

- COBRA Continuation Coverage “Election Notice” — This “Election Notice” includes COBRA Continuation Coverage Election Letter (MKT-53), COBRA Continuation Coverage Election Form (MKT-365) and Important Information about your COBRA Continuation Coverage Rights (MKT-54). The qualified beneficiaries should return the Election Form to you. You should keep the Election Form for your records.

- Notice by Qualified Beneficiaries of Second Qualifying Event (MKT-55/for future use if needed).

- Notice by Qualified Beneficiaries of SSA Disability Determination (MKT-56/for future use if needed).

- Continuation of Coverage Application (ENR-270 or ENR-421 for members enrolled in Alabama Personal Choice Network). The qualified beneficiaries should return the Application to you. If Blue Cross and Blue Shield of Alabama handles the COBRA billing for your group, you should forward the Application to us and keep a copy for your records.

COBRA

Notice by Qualified Beneficiaries of SSA Disability Determination

IMPORTANT: COBRA coverage may be extended for up to 29 months (from the date of the first qualifying event) if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability must start before the 60th day of COBRA coverage and must last until the end of the 18-month COBRA coverage period. You must timely deliver this notice to Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, AL 35298-0001, Fax: 205 220-6884 or 1 888 810-6884 (toll free) before the end of the 18-month period of COBRA coverage and within 60 days after the later of (i) the date of the initial qualifying event, (ii) the date on which coverage is lost under the Plan because of the initial qualifying event, or (iii) the date of the SSA disability determination. If you do not deliver this notice by the due date above, you will lose your right to an extension of COBRA continuation coverage. Please refer to the summary plan descriptions for your Plan for more information about COBRA coverage.

Group Health Plan Information: ______________________________

GROUP NAME GROUP NUMBER

Please check the group health plans (the "Plan") under which you had coverage on the day before the qualifying event:

☐ Health ☐ Dental

Covered Employee Information:

Please complete the information below for the former employee who was covered under the Plan:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
EMPLOYEE'S STREET ADDRESS CITY		STATE	ZIP	
DATE OF TERMINATION/REDUCTION IN HOURS MM/DD/YYYY				

Qualified Beneficiary Information:

Please complete the information below for each person (the employee, spouse and/or dependent children) who have COBRA coverage under the Plan:

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER	
STREET ADDRESS		CITY	STATE	ZIP
RELATIONSHIP TO EMPLOYEE				

Notice of SSA Disability Determination: Please complete all information below:

NAME OF DISABLED QUALIFIED BENEFICIARY	
DATE OF QUALIFIED BENEFICIARY DISABILITY MM/DD/YYYY	DATE OF SSA DISABILITY DETERMINATION MM/DD/YYYY

You must include a copy of the SSA disability determination letter with this notice.

____

SIGNATURE PRINT NAME DATE

MKT-56 (Rev. 1-2009)

Instructions for Notice of Unavailability of COBRA Continuation Coverage

If you receive a notice of qualifying event and you determine that any spouse or dependent described in the notice is not eligible for COBRA, you must send a Notice of Unavailability of COBRA Continuation Coverage ("Notice of Unavailability") to each ineligible person within 14 days after receiving the notice of qualifying event. Your notice must tell why the person is not eligible for COBRA.

You are also required to send a Notice of Unavailability to any ineligible person within 14 days after you receive a notice of a second qualifying event or a notice of a Social Security Administration disability determination.

If Blue Cross and Blue Shield of Alabama handles the billing and collection of COBRA premiums for your group, Blue Cross and Blue Shield of Alabama will send a Notice of Unavailability to ineligible persons who give notice of an SSA disability determination. You must provide all other Notices of Unavailability.

You may use this sample Notice of Unavailability of COBRA Continuation Coverage to notify each ineligible person of the unavailability of COBRA coverage or the unavailability of extended COBRA coverage. **Before using this form, you must fill in all the blanks and other requested information in this form. This form is available from Blue Cross and Blue Shield of Alabama by stock number MKT-57.**

COBRA

Notice of Unavailability of COBRA Continuation Coverage

Date of Notice: ______________________________
MM/DD/YYYY

To: ____
NAME OF EMPLOYEE, SPOUSE, DEPENDENT CHILDREN, AS APPROPRIATE

Address: ____
ADDRESS TO WHICH NOTICE IS BEING SENT

Re: Unavailability of COBRA Coverage or Extended COBRA Coverage

On ________________________, we received from you, or persons on your behalf, a notice of certain information regarding an event that occurred on ________________________ that may constitute a "qualifying event" under COBRA for the following person(s) under the group health plan or plans listed below:

NAME	CONTRACT NUMBER	TYPE OF COVERAGE
1.		
2.		
3.		
4.		

Your notice stated or implied that you and/or one or more of your dependents are "qualified beneficiaries" entitled to COBRA continuation coverage or an extension of COBRA continuation coverage because of an event that is a:

☐ **FIRST QUALIFYING EVENT**
- ☐ Divorce from covered employee
- ☐ Loss of dependent child status under the plan

☐ **SECOND QUALIFYING EVENT**
- ☐ Divorce from covered employee
- ☐ Loss of dependent child status under the plan
- ☐ Covered employee's enrollment in Medicare
- ☐ Death of covered employee

The Plan Administrator reviewed your notice and determined that COBRA continuation coverage or COBRA extended continuation coverage is not available to the person(s) listed above. The reason for this decision is as follows:

____

____

If this is for a first qualifying event notice:
As a result, your coverage under the plans listed above terminated or will terminate on ______________________________. Please note that, effective on the termination date, any medical claims for the person(s) named above will not be paid by the above-listed plans.

If this is for a second qualifying event notice:
As a result, you are not entitled to an extension of COBRA coverage and your COBRA coverage terminated or is scheduled to terminate on ________________________________ assuming you timely pay your COBRA premiums.

If any of the persons listed above do not reside at the address to which this notice was sent, please notify us at the address listed at the end of this notice and give us the new address for these persons, so that we may provide a copy of this notice to them.

If you disagree with this determination or if you have any questions about this notice, please contact us at

____

PLAN ADMINISTRATOR'S NAME | ADDRESS | PHONE NUMBER

MKT-57 (10-2004)

INSIDE BACK COVER