1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bcbst.com

Note: This form should be completed by the employer and immediately sent to BlueCross BlueShield of Tennessee.

COBRA Coverage Continuation Notice

-- Confidential --

Please Print Clearly and Fully. Complete Form in Blue or Black Ink.

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Date: ___ / ___ / _____

BCBST Medical Group No: ________

BCBST Dental Group No: ________
(If different from Medical)

Name of Employer: ____________________

Applicant Information **(the person applying for COBRA coverage, i.e. employee, employee's spouse, or employee's dependent children):**

Applicant's Medical ID No: ____________

Applicant's Dental ID No: (If different from Medical) ____________

Applicant's Date of Birth: ___ / ___ / _____

Last Name ____________ First Name ____________ MI ___ Male ☐ Female ☐

Applicant's Social Security No: ___ – __ – ____

Applicant's Daytime Phone No (including area code): ___ – ___ – ____

Applicant's Street Address (including apartment number): ____________________

City ____________ State ___ Zip _____

If the applicant experiencing the Qualifying Event is not the employee, please complete the following information:

Employee's BCBST Medical ID No: ____________

Employee's BCBST Dental ID No: (If different from Medical) ____________

Employee's Social Security No: ___ – __ – ____

Employee Last Name ____________ First Name ____________ MI ___

Applicant's Relationship to Employee: Dependent Child ☐ Spouse ☐

COBRA Qualifying Event Causing Loss of Coverage (Check One):

Date of Qualifying Event: ___ / ___ / _____

☐ Involuntary Termination (for reason other than reduction in hours or gross misconduct)

☐ Other Employee Termination (for reason other than gross misconduct)

☐ Employee Becomes Eligible for Medicare ☐ Death of Covered Employee ☐ Dependent Child Ceases to be "Dependent Child" ☐ Divorce or Legal Separation

☐ Reduction in Hours ☐ Other Reason for Loss of Coverage (explain): ____________________

Coverage Applying For (the type coverage employee had at the time of the qualifying event):

Health:	☐ Individual	☐ EE/Spouse	☐ EE/Child	☐ Family
Dental:	☐ Individual	☐ EE/Spouse	☐ EE/Child	☐ Family
Vision:	☐ Individual	☐ EE/Spouse	☐ EE/Child	☐ Family

Other Carrier Information/Benefit Plan:

____

____

GB-108 (09.09)

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

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COBRA Dept: Phone: 423-535-3174 or 1-800-364-6121 Fax: 423-591-9243

COBRA Coverage Continuation Notice
(continued)

Applicant's Name: ______________________ **Social Security No:** ______________________

List Dependents Eligible for Coverage:

Last Name | First Name | MI | Male ☐ | Female ☐ | Social Security No: ___-__-____

Date of Birth: __/__/____ Relationship to Employee: Dependent Child ☐ Spouse ☐

Last Name | First Name | MI | Male ☐ | Female ☐ | Social Security No: ___-__-____

Date of Birth: __/__/____ Relationship to Employee: Dependent Child ☐ Spouse ☐

Last Name | First Name | MI | Male ☐ | Female ☐ | Social Security No: ___-__-____

Date of Birth: __/__/____ Relationship to Employee: Dependent Child ☐ Spouse ☐

Last Name | First Name | MI | Male ☐ | Female ☐ | Social Security No: ___-__-____

Date of Birth: __/__/____ Relationship to Employee: Dependent Child ☐ Spouse ☐

Date Employer Received Notification from Employee of Qualifying Event: __/__/____

Date COBRA Coverage Continuation Begins **(When group coverage ends and COBRA begins):** __/__/____

Date COBRA Billing Begins **(Date BlueCross BlueShield of Tennessee starts billing COBRA participant):** __/__/____

☐ **Primary Event**

☐ **Secondary Event***

*If Secondary Event, list date of Primary Event: __/__/____

☐ **Send Qualifying Event Notification to Employee**
(Send when employee is first eligible for COBRA)

☐ **Bill Only**
(Send to existing COBRA participants at time of enrollment
with BlueCross BlueShield of Tennessee)

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

______________________ **Name of Person Completing Form**

______________________ **Telephone No.**

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