WEA SELECT
COBRA – Continued Group Coverage Application

PREMERA | BLUE CROSS

Please complete this form and return it to your employer with any subscription charges that you are required to contribute. Be sure you fill out this form carefully. Incomplete or incorrect information may delay your continued coverage.

School District Name:

Employee Information

Employee Name (Last) (First) (MI) | Home Phone ( )

Mailing Address | Premera ID Number

City | State | ZIP

Does a dependent have a different mailing address? ☐ No ☐Yes, Name ____________
Mailing address ____________ City ____________ State _____ ZIP _______

Other Coverage Information: Will you or your dependents enrolled on your WEA Select Plan have any other active medical, vision, or Medicare coverage when this coverage begins? ☐ **No** ☐ **Yes,** complete and attach an **Other Coverage Questionnaire** form.

WEA Select Plan Selection and Enrollment

Note: Please check the box below that corresponds to your current health plan coverage. You cannot choose a plan you are not already enrolled on or a plan not offered by your school district or employer group. Plan changes are allowed only during open enrollment.

WEA Select Medical Plan Selection

☐ Waive Medical ☐ Plan 2 ☐ Plan 3 ☐ Plan 5 ☐ EC– A ☐ EC– B ☐ EC– C ☐ HDHP

WEA Select Vision Plan Selection

☐ No WEA Vision ☐ WEA Plan A ☐ WEA Plan B ☐ WEA Plan C ☐ WEA Plan D ☐ WEA Plan E ☐ WEA Plan F

Please List ALL Dependents to be Covered

	ID card names limited to 26 characters and spaces Name (Last, First, MI)	Social Security No.	Gender M / F	Birth Date MM /DD/ YYYY	Medical √ box	Vision √ box	Dental √ box
Self				/ /	☐Yes ☐No	☐Yes☐No	☐Yes ☐No
Spouse/ DP				/ /	☐Yes ☐No	☐Yes☐No	☐Yes ☐No
Child				/ /	☐Yes ☐No	☐Yes☐No	☐Yes ☐No
Child				/ /	☐Yes ☐No	☐Yes☐No	☐Yes ☐No
Child				/ /	☐Yes ☐No	☐Yes☐No	☐Yes ☐No
Child				/ /	☐Yes ☐No	☐Yes☐No	☐Yes ☐No

I understand that only the enrollees listed on this form will receive continued coverage. I also understand that each enrollee must have been covered before the qualifying event, except for adding family members as stated in my benefit booklet. I understand the terms and limitations stated on both sides of this form. I further authorize the Premera Blue Cross Plan, at its option, to pay providers directly for services rendered. **This form supersedes all previous forms I have submitted.**

X ____________________ ____________
Employee Signature Date Signed

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Please keep a copy for you records.

To be Completed by School District: Send white and yellow copies to Premera Blue Cross; retain pink copy for your records.

COBRA Effective Date: ____________ **Date Group Coverage Ended:** ____________

Qualifying Event: ☐ Retirement ☐ Over-age Dependent ☐ Divorce/Legal Separation ☐ Termination ☐ Work Hours Reduced

☐ Other (please describe) ____________ **Date of Qualifying Event** ____________

The above enrollee(s) may continue group health coverage for up to (check one)

☐ 18 months (for employees and dependents) ☐ An additional 11 month (Attach a copy of the "Notice of Award")

☐ 36 months (for dependents) ☐ _____ months (balance of continuation period)

X ____________________ ____________
Employer's Authorized Signature Date Signed

Premera Blue Cross Use: ID Number: ID Card ☐ Date: / / Initials:

PLEASE READ CAREFULLY

ENROLLMENT CONDITIONS

A. This form must be completed and returned to the employer no more than 60 days from:

1. the date your active group coverage ended; or
2. the date you were notified of your rights under COBRA continuation; whichever date is later.

You must submit subscription charges for continuation coverage to the employer no later than 45 days from the signature date of your application.

B. A covered spouse or child choosing continued coverage due to a divorce, legal separation, or a child's loss of dependent eligibility must notify the participating employer group no more than 60 days after either a qualifying event or the dependent's coverage ends, whichever date is later.

C. If the conditions for enrollment are met, continued coverage will begin as of the day the active group coverage ended. However, if the above conditions are not met, you and your dependents will lose the right to continued coverage, and we will not enroll you.

WHEN CONTINUED COVERAGE ENDS

A. Your continued coverage under this plan will end when the first of the following occurs:

1. The date your bargaining unit/employee classification no longer participates in this plan or the date the contract between the Washington Education Association and Premera Blue Cross is canceled.
2. The continuation period expires.
3. Subscription charges are not paid when due or within the grace period.
4. You become entitled to Medicare after the date you elect COBRA coverage.
5. You become covered under any active group health plan after the date you elect COBRA coverage. However, if the new plan has an exclusion or limitation for your pre-existing condition, coverage does not end for this reason until the limitation or exclusion no longer applies.
6. When your coverage is extended from 18 to 29 months due to disability, that extended coverage ends when there is a final determination that you are no longer disabled under the Social Security Act.

Once ended, continued coverage may not be reapplied for.

B. Please direct any questions about COBRA and enrollment procedures to the COBRA group administrator for this COBRA coverage.

Medical plan selection and enrollment (Underwritten by Premera Blue Cross, PO Box 327, Seattle, WA 98111)

Vision plan selection and enrollment (Underwritten by Premera Blue Cross. Plans B, C, E & F administered by Vision Service Plan (VSP), PO Box 997105, Sacramento, CA 95899).

PREMERA PRIVACY POLICY PRACTICES

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, health-care providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other health-care plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at www.premera.com/wea. To have forms mailed to you, please call the WEA Select Service Team at 1-800-932-9221.

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association