

COBRA QUALIFYING EVENT NOTIFICATION FORM

In order to receive COBRA continuation coverage (COBRA), **timely notice** must be provided of each qualifying event. In some instances, COBRA may be extended by a disability or second qualifying event if timely notice is provided. **Timely notice** deadlines are listed below. **Timely notice** must be submitted to:

Blue Cross and Blue Shield of Montana
 COBRA Administrator
 P.O. Box 4309
 Helena, MT 59604

Note: This COBRA Qualifying Event Notification Form does not allow you to elect COBRA continuation coverage. Within 14 days of receipt of this COBRA Qualifying Event Notification Form, the COBRA administrator will mail a **COBRA Continuation Coverage Election Notice and Election Form** to each qualified beneficiary. In order to elect COBRA continuation coverage, the COBRA Continuation Coverage Election Notice and Election Form must be returned to the COBRA administrator by the deadline specified in that form.

Covered Employee Name	Subscriber Identification Number/ Health Plan ID	Telephone
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Employee Mailing Address	City/Town	State	ZIP Code
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Group Health Plan _____

PART 1. INITIAL COBRA QUALIFYING EVENT Date Qualifying Event Occurred ___ / ___ / ___

Timely Notice: Within 60 days from the date of the event **Responsibility for Notification:** Employee

<input type="checkbox"/> Employee's divorce or legal separation	<input type="checkbox"/> Dependent child ceased to be eligible under group health plan.
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Timely Notice: Within 60 days from the date of the event **Responsibility for Notification:** Employer

<input type="checkbox"/> Reduction in work hours	<input type="checkbox"/> Termination of employment (other than for gross misconduct)
<input type="checkbox"/> Employee's death	<input type="checkbox"/> Employee Medicare-eligible, spouse, dependents losing eligibility as a result of Medicare eligibility

Qualified Beneficiary(ies)

Name	Address	Subscriber ID/Plan Identification Number	Relationship To Employee

Completed by: Please Print and Sign Your Name _____

Date _____

PART 2. SECOND COBRA QUALIFYING EVENT

If the original COBRA continuation coverage period was 18 months, the following qualifying events will extend coverage for an additional 18 months (for a total of 36 months) for the covered spouse and covered dependent children if the event would have originally caused a loss of coverage.

Timely Notice: Within 60 days from the date of the event **Responsibility for Notification:** Qualified beneficiary

<input type="checkbox"/> Death of former employee	<input type="checkbox"/> Divorce or legal separation
<input type="checkbox"/> Former employee enrolls in Medicare Part A, Part B, or both	<input type="checkbox"/> Dependent child ceases to be eligible under group health plan as dependent child

Qualified Beneficiary(ies)

Name	Address	Subscriber ID/Plan Identification Number	Relationship To Employee

Completed by: Please Print and Sign Your Name _____

_____ Date

PART 3A. EXTENSION DUE TO MEDICARE DISABILITY

Applies to any qualified beneficiary determined by the SSA to be disabled prior to or at any time during the first 60 days of COBRA continuation coverage.

Timely Notice: The qualified beneficiary must notify the COBRA administrator before the end of the 18-month period of COBRA continuation coverage. COBRA continuation coverage may be extended up to an additional 11 months, for a total of 29 months.

Responsibility for Notification: Qualified beneficiary

I have enclosed a copy of the SSA Disability Determination (required).

Name of Disabled Qualified Beneficiary

Date of SSA Determination

Date Disability Began

Please extend COBRA continuation coverage up to an additional 11 months for the following qualified beneficiaries.

Qualified Beneficiary(ies)

Name	Address	Subscriber ID/Plan Identification Number	Relationship To Employee

Completed by: Please Print and Sign Your Name _____

_____ Date

PART 3B. DETERMINATION THAT QUALIFIED BENEFICIARY IS NO LONGER DISABLED

Timely Notice: Notice must be provided within 30 days after the date of the SSA’s determination that beneficiary is no longer disabled.

Responsibility for Notification: Qualified beneficiary with disability

I have enclosed a copy of the SSA Disability Determination (required).

Note: The COBRA continuation coverage of all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA determination that the qualified beneficiary is no longer disabled.

_____	_____	_____
Name of Beneficiary	Date of SSA Determination	Date Disability Ended

_____	_____
Completed by: Please Print and Sign Your Name	Date

If you have any questions, please contact Blue Cross and Blue Shield of Montana at 1-800-447-7828.

COBRAQEFORM