

SUBMIT TO: Arkansas Blue Cross and Blue Shield; HIPAA Unit, Suite 900; POB 1151; Little Rock, AR 72203-1151; FAX 501-378-2926

Arkansas State Group Continuation Coverage Election Form

Employee's Name: _____ ID #: _____

Dependent Name(s): _____ Former Employer: _____

_____ Insurer _____

_____ Group #: _____

The State of Arkansas Continuation Law (A.C.A. §23-86-114) allows a former employee or former dependent to extend their group health insurance coverage for up to one hundred twenty (120) days. In order to be eligible for this option, the former employee or dependent must have been continuously covered under the group health insurance policy for at least three (3) consecutive months prior to employment termination or change in dependency status and must make the election by notifying the insurer no later than 10 days after employment termination or change in dependency status. The group health insurance premium must be paid in full by the former employee or dependent to the employer (policyholder) as specified below. ***In the event extension of coverage is due to involuntary termination of employment on or after February 17, 2009 and prior to February 28, 2010, the insurance premium due from the former employee will be 35% of the group health insurance premium.*** Failure to pay this premium will result in cancellation of coverage for the employee and/or any dependents.

I, _____, wish to continue my group health insurance coverage under the State of Arkansas Continuation Law beginning ___/___/___.

I am requesting continuation of my group health insurance coverage because of involuntary termination of employment.

The premium amount of \$ _____ must be paid on the first of each month to my former employer beginning ___/___/___ or my coverage will be terminated. ***If continuation is due to my involuntary termination of employment on or after February 17, 2009 and prior to February 28, 2010, the insurance premium due from the former employee will be 35% of the above stated premium amount.*** This continuation of coverage shall terminate on the earliest of:

- One hundred twenty (120) days after the extended coverage begins;
- The date the former employee or dependent fails to make any premium payments to the former employer or the date the former employer fails to pay the premium to the insurer;
- The date on which the former employee or dependent becomes eligible for Medicare;
- The date on which the former employee or dependent is covered for similar benefits under another group or individual policy;
- The date on which the former employee or dependent is eligible for similar benefits under another group plan whether insured or uninsured;
- The date on which similar benefits are provided for, or available to, the former employee or dependent under any state or federal law; or
- The date on which the group policy terminates.

I have read the statements above and do not wish to continue group health insurance coverage under the State of Arkansas Continuation Law (A.C.A. §23-86-114), for myself and/or any eligible dependents.

Signature of Employee

Date of Signature

Signature of Group Administrator

Date of Signature