

CBIA Service Corp. — COBRA/State Continuation Services

CONTINUANT TAKEOVER FORM

APPENDIX A

(To transfer current COBRA/State Continuation continuants to CBIA Service Corp. — COBRA/State Continuation Services)

INSTRUCTIONS: Please print clearly

- Fill out just one form per family unit (Qualified Beneficiary and Dependents)
- Please do not use this form to report new Qualifying Events — use the COBRA/State Continuation Notification Form.
- Please see back side of this form for further instructions.

COMPLETE THIS FORM AND RETURN IT TO:

CBIA Service Corp. — COBRA/State Continuation Services
 350 Church Street
 Hartford, CT 06103-1126
 Fax: 860-278-0883

PLEASE CHECK ONE BOX: **Original notice** (If FAXED, do not mail copy) **Revision...** to a form that was previously sent

1) From: (Company) _____		2) CBIA Case Number _____	
3) Please be advised that the following is currently on COBRA/State Continuation. (Check one box only) <input type="checkbox"/> (E)mpleado <input type="checkbox"/> (D)ependent		4) Social Security Number of Qualified Beneficiary _____ - _____ - _____	
5a) Name of COBRA/State Continuation continuant (last, first, mi) (Please print) _____			
5b) Street Address _____		5c) City _____	5) State _____
5e) ZIP Code _____			
6) Home Phone # (if available) _____ - _____ - _____		7) Date of Birth of Qualified Beneficiary ____/____/____ M M D D Y Y Y Y	8) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
9) Marital Status (check one box only.) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		15) Check the current plan code coverages. CBIA administers only plan code coverage options that are permitted by your plan or carrier. (check one box only.) <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	
10) If the above individual in box #5 is a dependent of an employee/former employee, please complete the following: Employee Name (last, first, mi) _____ Employee SSN _____ - _____ - _____ Dependent's relationship to Employee _____			
11) Qualifying Event Date _____ M M D D Y Y Y Y			
12) Last day of pre-COBRA Coverage (cannot be prior to Qualifying Event Date) _____ M M D D Y Y Y Y		16) At the time of the termination or reduction in hours, was the employee eligible to receive Social Security income? <input type="checkbox"/> No <input type="checkbox"/> Yes	
13) First premium due-date for which CBIA is to begin COBRA/State Continuation billing _____ M M D D Y Y Y Y		17) If the COBRA/State Continuation continuant has dependents covered, please complete the following. (Please print) Dependent Name (first, last, mi) _____ Birth Date: Mo. _____ Day _____ Yr. _____ Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number _____ - _____ - _____ Relationship to employee _____ Qualified Beneficiary <input type="checkbox"/> Dependent Name (first, last, mi) _____ Birth Date: Mo. _____ Day _____ Yr. _____ Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number _____ - _____ - _____ Relationship to employee _____ Qualified Beneficiary <input type="checkbox"/> Dependent Name (first, last, mi) _____ Birth Date: Mo. _____ Day _____ Yr. _____ Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number _____ - _____ - _____ Relationship to employee _____ Qualified Beneficiary <input type="checkbox"/>	
14) Qualifying Event that caused loss of coverage (check one) Continuation of coverage for 30 months: <input type="checkbox"/> Employee's termination of employment (includes voluntary resignation, involuntary termination (except when due to gross misconduct), retirement, layoff, or leave of absence) <input type="checkbox"/> Employee's reduction in work hours (includes work stoppage or strike) Continuation of coverage for 36 months: <input type="checkbox"/> Death of covered employee/retiree <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage <input type="checkbox"/> Ineligibility of dependent child <input type="checkbox"/> Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title II (bankruptcy) United States Code			
Form completed by: _____ Date _____			
Name (print) _____		Phone _____ Fax _____	

TRANSFERRING CURRENT COBRA/STATE CONTINUANTS TO CBIA SERVICE CORP. — COBRA/STATE CONTINUATION SERVICES

Instructions for completing Continuant Takeover Form (on reverse side)
(use one form per family unit)

This form is only needed if you have current COBRA/State Continuant to be transferred to
CBIA Service Corp. — COBRA/State Continuation Services.

One form should be completed for each family unit and sent to:

**CBIA Service Corp. — COBRA/State Continuation Services,
350 Church Street, Hartford, CT 06103-1126**

SECTION 1:

Enter your company name.

SECTION 2:

Enter your CBIA Case number.

SECTION 3:

Check appropriate box to indicate whether
Continuant is an employee or dependent. (Check
one box only.)

SECTION 4:

Enter the Continuant's complete nine-digit Social
Security number.

SECTION 5:

Enter Continuant's complete name (last, first,
middle initial) and complete mailing address
(street, city, state and ZIP Code.)

SECTION 6:

Enter Continuant's home phone number, includ-
ing area code, if available.

SECTION 7:

Continuant's date of birth. (month, day, year)

SECTION 8:

Check appropriate box to indicate the
Continuant's gender (Male or Female)

SECTION 9:

Check appropriate box to indicate marital status
of Continuant.

SECTION 10:

If the Continuant is a dependent of an employee
or former employee, enter employee's complete
name (last, first, middle initial), employee's nine-
digit Social Security Number and Continuant's
relationship to employee.

SECTION 11:

Enter the month, day and year of the Qualifying
Event.

SECTION 12:

Enter the LAST DAY (month, day, year) of the
Continuant's pre-COBRA/State Continuation of
Coverage.

SECTION 13:

Enter the FIRST PREMIUM DUE DATE for which
CBIA Service Corporation — COBRA/State
Continuation Services is to begin billing.

SECTION 14:

Check appropriate box (check one box only) to
indicate the type of Qualifying Event. "Employee's
termination of employment" includes voluntary
resignation, involuntary termination (except for
termination due to gross misconduct), retirement,
layoff, or leave of absence. Employee's reduction
in hours includes work stoppage (strike)."

SECTION 15:

Indicate coverage by checking the box of the
appropriate plan code.

SECTION 16:

Check appropriate box (Yes or No) to indicate
whether at the time of the termination or reduc-
tion in hours, the employee was eligible to
receive Social Security income.

SECTION 17:

Provide information if the Continuant has
dependents covered, and indicate whether the
individual is a Qualified Beneficiary and was cov-
ered under the group health plan at the time of
the original Qualifying Event or was born to or
placed for adoption with a covered employee
during the period of COBRA/State Continuation
coverage.