

# COBRA/State Continuation Change Form CBIA Health Connections



**1. EMPLOYER GROUP NAME:** \_\_\_\_\_  
**Case/Cert#:** \_\_\_\_\_

**Change** (indicate reason)  Requested effective date: \_\_\_\_\_

<input type="checkbox"/> Add dependent (provide date of event) _____ Marriage _____ Birth _____ Adoption _____ Loss of other coverage (attach Certificate of Creditable Coverage) <input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Remove Dependent(s) (indicate who is to be removed in section 3 below) <input type="checkbox"/> Terminate all coverage <input type="checkbox"/> Terminate medical coverage only <input type="checkbox"/> Terminate dental coverage only <input type="checkbox"/> Other (please specify) _____
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**2. CONTINUANT INFORMATION - please print clearly and complete the entire form** Rev 9/05

Former Employee (or continuant) Name	Home Telephone ( )
Street Address <span style="float: right;">Apt #:</span>	Work Telephone ( )
City, State, ZIP	

**3. LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS IMPACTED BY THE CHANGE UNDER YOUR COVERAGE.**

	Sex	Social Security #	Primary Care Physician Name and ID Number
Self (Last Name, First Name, Middle Initial)	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Child*	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Child*	<input type="checkbox"/> M <input type="checkbox"/> F	- -	
Child*	<input type="checkbox"/> M <input type="checkbox"/> F	- -	

Are you or your spouse entitled to Social Security Disability?  Yes  No  
 Are any of the dependent children listed above eligible for coverage as a result of an incapacity (mental/physical disability)?  Yes  No  
 Are you or any of your dependents covered by another health plan?  Yes  No If yes, list carrier and plan number:  
 \*If dependent child(ren) listed are 19 (the limiting age) and attend school on a full-time basis, **attach a completed Student Verification Form.**

<p><b>4. MEDICAL</b> NOTE: not all groups offer medical through CBIA</p> <p><b>MEDICAL Coverage Level:</b> <input type="checkbox"/> Waive medical  <input type="checkbox"/> Self  <input type="checkbox"/> Self + Spouse  <input type="checkbox"/> Self + Child(ren)  <input type="checkbox"/> Family</p> <p><b>Health Plan</b> (choose 1 health plan &amp; 1 benefit)  <input type="checkbox"/> CIGNA <input type="checkbox"/> Health Net  <input type="checkbox"/> ConnectiCare <input type="checkbox"/> Oxford</p> <p><b>Plan of Benefits</b>  <input type="checkbox"/> HMO \$10 <input type="checkbox"/> POS \$10 <input type="checkbox"/> POS \$10 Open Access  <input type="checkbox"/> HMO \$20 <input type="checkbox"/> POS \$20 <input type="checkbox"/> POS \$20 Open Access  <input type="checkbox"/> HMO \$30 <input type="checkbox"/> POS \$30</p>	<p><b>5. DENTAL – AETNA</b> NOTE: not all groups offer dental through CBIA</p> <p><b>Dental Coverage Level:</b>  <input type="checkbox"/> Waive dental  <input type="checkbox"/> Self  <input type="checkbox"/> Self + Spouse  <input type="checkbox"/> Self + Child(ren)  <input type="checkbox"/> Family</p>	<p><b>6. AUTHORIZATION AND ACCEPTANCE</b></p> <p>I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified.</p> <p>I authorize any provider, insurance company, employer or organization to release any information, on me or my dependents, regarding the medical, dental, mental, confidential HIV related information, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this Plan. The information provided is true and correct to the best of my knowledge.</p> <p><b>I understand my coverage and benefits may be affected by failure to provide complete and accurate information. Important! The Continuant's signature is required before submitting this application. CBIA reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.</b></p> <p>_____ Continuant Signature <span style="float: right;">Date</span></p>
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**Please retain a copy for your files**