

TRANSFERRING CURRENT COBRA/ STATE CONTINUANTS TO CBIA Federal COBRA or State Continuation Services

Serviced by Vimly Benefit Solutions Inc. (VBS)

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

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

CBIA Insurance Administration

350 Church Street, Hartford, CT 06103-1126 | Fax: 860-278-0883 | Email: HCService@cbia.com

SECTION 1:

Enter your company name.

SECTION 2:

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

SECTION 3:

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

SECTION 4:

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

SECTION 5:

Enter the Continuant's home phone number, including area code, if available.

SECTION 6:

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

SECTION 7:

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

SECTION 8:

Check appropriate box to indicate marital status of Continuant.

SECTION 9:

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 10:

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

SECTION 11:

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

SECTION 12:

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 13:

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

SECTION 14:

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

SECTION 15:

Provide information if the Continuant has dependents covered and indicate whether the individual is a Qualified Beneficiary and was covered 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 Federal COBRA or State Continuation coverage.

CBIA Federal COBRA or State Continuation Services

Continuant Takeover Form

Appendix A

(To transfer current Federal COBRA or State Continuation continuants to CBIA)

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 Federal COBRA or State Continuation Qualifying Events Form.
- Please see back side of this form for further instructions.

COMPLETE THIS FORM AND RETURN IT TO:

CBIA Insurance Administration
 350 Church Street
 Hartford, CT 06103-1126
 Fax: 860.278.0883
 Email: HCService@cbia.com

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

1) From: (Company) _____	
2) Please be advised that the following is currently on Federal COBRA or State Continuation. (Check one box only) <input type="checkbox"/> Employee <input type="checkbox"/> Dependent	3) Social Security Number of Qualified Beneficiary _____
4a) Name of Federal COBRA or State Continuation Continuant (last, first, mi) (Please print)	
4b) Street Address _____	4c) City _____
4d) State _____	4e) ZIP Code _____
5) Home Phone # (if available) _____	6) Date of Birth of Qualified Beneficiary ____/____/____
7) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
8) Marital Status (check one box only): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced	14) At the time of termination or reduction in hours, was the employee eligible to receive Social Security income? <input type="checkbox"/> No <input type="checkbox"/> Yes
9) If the above individual listed in box #4 is a dependent of an employee/ former employee, please complete the following: Employee Name (last, first, mi): _____ Employee SSN: _____ Dependent's Relationship to Employee: _____	15) If the Federal COBRA or State Continuation Continuant has dependents covered, please complete the following. (Please print) Dependent Name (first, last, mi): _____ Birth Date: Mo. _____ Day _____ Yr. _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____ Relationship to employee: _____ Qualified Beneficiary <input type="checkbox"/>
10) Qualifying Event Date ____/____/____	Dependent Name (first, last, mi): _____ Birth Date: Mo. _____ Day _____ Yr. _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____ Relationship to employee: _____ Qualified Beneficiary <input type="checkbox"/>
11) Last day of Continuation Coverage (cannot be prior to Qualifying Event Date): ____/____/____	Dependent Name (first, last, mi): _____ Birth Date: Mo. _____ Day _____ Yr. _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____ Relationship to employee: _____ Qualified Beneficiary <input type="checkbox"/>
12) Qualifying Event that caused loss of coverage (check one): <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) <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 11(bankruptcy) United States Code	Form completed by: Name: _____ Date: ____/____/____ Phone: _____ Fax: _____
13) 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	