

CONTINUATION COVERAGE FORM

(Date Notified)

To _____
(Name of Employee or Qualified Beneficiary)

(Now Covered under ID No.)

From: **COAHOMA COMMUNITY COLLEGE & AHS**
(Name of Employer)

This is to advise you that you and/or your covered family members have the right to continuation coverage under the State Health Plan. Each person covered on the day your health plan is terminated can elect continuation coverage. A child born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage also has a right to continuation coverage. A federal law commonly referred to as COBRA allows you to extend this coverage at your own expense for a specified period of time.

Under the law, you have 60 days from the date you would lose coverage because of a "qualifying event" or from the date you receive this notice, whichever is later, to inform the State's Claims Administrator that you want COBRA. If you waive your election of continuation coverage, your group health insurance will terminate as a result of a "qualifying event". If you choose continuation coverage, the Plan is required to reinstate your coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees.

As a result of the "qualifying event", your coverage terminates Therefore, continuation coverage will end

You and/or your covered dependents are entitled to continuation coverage for the time specified below because of the following qualifying event. If it is for 36 or 48 months, a new Enrollment Form must be completed.

18 Months	36 Months	48 Months
<input type="checkbox"/> Termination of Employment (for reasons other than gross gross misconduct)	<input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Ineligible dependent child <input type="checkbox"/> Medicare-ineligible spouse/children	<input type="checkbox"/> Death of Employee
<input type="checkbox"/> Loss of coverage due to reduction in work hours		

The monthly premium due for continuation coverage is \$ **170.00** for participant only coverage; **\$335.00** for participant and spouse coverage; **\$ 418.00** for participant, spouse and child(ren) coverage; or **\$293.00** for participant and child(ren) coverage. These rates include 102 percent of the group premium amount. You have 45 days from the date you elect continuation coverage to make the first payment which includes all arrears fees.

Premiums are due the 1st of each month. Premiums not received within 30 days of the due date will be considered delinquent. Failure to pay premiums timely will result in cancellation.

Certain disabled qualified beneficiaries can have an 11 month extension from 18 to 29 months. To qualify,

the individual must be disabled at the time of the termination of employment or reduction of employment hours or become disabled at any time during the first 60 days of COBRA continuation coverage. The disability must be determined under the Social Security Act. notice of disability determination must be given to the Claims Administrator within 60 days after the date of disability determination and within the 18 month period after the covered employee's qualifying event for continuation coverage. In such cases, the qualified beneficiary will be charged 150 percent of the group fee for the 11 month extended period.

TO BE COMPLETED BY EMPLOYEE/QUALIFIED BENEFICIARY

I acknowledge receipt of the above notice of right to continuation coverage. For myself and family members, if any, I elect:

() Not to have continuation coverage.

() To have continuation coverage, and understand that I am responsible for payment of the entire premium amount; 102 percent of the group premium or 150 percent of the group premium amount for disability.

I understand that continuation coverage ceases at the expiration of the allowed 18, 36 or 48 months, as the case may be. It can end earlier in case of any of the following:

1. The Plan no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time.
3. I become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have.
4. I become entitled to Medicare;
5. I extend coverage for up to 29 months due to disability and there has been a final determination that I am no longer disabled.

Signature: _____
Employee/Qualified Beneficiary

Date Signed _____
Employee/Qualified Beneficiary

Signature: _____
Spouse (if applicable)

This to form should be completed and sent to:

Blue Cross & Blue Shield of Mississippi
P O Box 23098
Jackson, MS 39225-3098

Make checks/money orders payable to: Department of Finance and Administration