

IMPORTANT: Please read instructions on reverse before completing this application



Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association



Regence HealthWise

An Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Utah and its non-insurer subsidiary, Regence ValueCare and/or Regence HealthWise.

COBRA, UTAH mini-COBRA/STATE CONTINUATION, NETCARE CONTINUATION OR USERRA

(Instructions on reverse side)

COBRA CONTINUATION STATE CONTINUATION (12 months) NETCARE CONTINUATION (12 months) MILITARY LEAVE OF ABSENCE (USERRA)
 High Deductible Low Deductible

Employee Name _____ Employee Identification Number _____
Employer (or Former Employer) Name _____ Group Number _____

Reason for election (Qualifying Event):
 Employee's termination of employment or reduced working hours Employee's Medicare entitlement Employee's child's loss of dependent status
 Voluntary termination Employee's death Military Training / Active Duty
 Involuntary termination Employee's divorce or legal separation Former Employer's bankruptcy

Date of Qualifying Event (Last day of group coverage): _____

If the qualifying event is termination of employment or reduction in working hours, is coverage to be continued for the Employee? Yes No

Coverage is to be continued for:

| Qualified Beneficiaries' Names | Date of Birth Mo/Day/Yr | Social Security Number | Relationship to Employee | Other Group Health/Dental/Drug Coverage (Information including Medicare) | | |
|--------------------------------|----------------------------|---------------------------|--------------------------------|-----------------------------------------------------------------------------|---------|--------|
| | | | | Carrier Name | Medical | Dental |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

Qualified Beneficiaries' Mailing Addresses:

| | |
|---------------------------------------|---------------------------------------|
| Name _____ | Name _____ |
| Street _____ | Street _____ |
| City _____ State _____ ZIP Code _____ | City _____ State _____ ZIP Code _____ |

SIGNATURE

I authorize any source to release to Regence BlueCross BlueShield of Utah, Regence ValueCare and/or Regence HealthWise (hereafter referred to as "the Plan") any medical, health, employment and/or insurance information requested. I agree to abide by the Plan's enrollment regulations.

I understand there may not be participating physicians available in all fields.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Signatures of Qualified Beneficiaries _____
(Parent may sign for qualified dependent child beneficiary.) _____

Date _____

INSTRUCTIONS

GENERAL INFORMATION

- Please print your answers in either black or blue ink in all blanks.
- Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A."
- Be sure to sign and date the form.

EMPLOYEE INFORMATION

- Be sure to include the employee identification and group numbers of the coverage to be continued.

REASON FOR ELECTION

- Please check the reason continued coverage is requested and, under "Date of Qualifying Event," include the termination date of the group coverage.

QUALIFIED BENEFICIARIES

- Please list the name, birthdate (month, day and year), Social Security number and relationship to Employee of every qualified beneficiary requesting continuation of coverage. This may include the Employee if the Reason for Election is termination of employment or reduction in working hours.
- For every beneficiary covered by another group plan, including Regence BlueCross BlueShield and Medicare, complete the appropriate health/dental/drug carrier name and policy number. Make sure complete information is given for every beneficiary covered by other plans.

SIGNATURE

- Each qualified beneficiary must sign this application. A parent may sign for dependent children.
- Please include the date application was completed.

PRE-EXISTING CONDITIONS

- Any coverage issued in connection with this application may contain a limitation on the coverage of pre-existing conditions. If you have prior creditable coverage, it may be available to reduce the period of the pre-existing condition limitation. Regence BlueCross BlueShield of Utah will assist you in obtaining a certificate of creditable coverage if necessary.