BlueCross BlueShield of Montana

Employee/Dependent COBRA Election Form

As explained in the letter accompanying this form, to elect COBRA continuation coverage, this form must be completed, signed, and received by Blue Cross and Blue Shield of Montana within 60 days from the date of the letter. When you are terminated (except for gross misconduct) or your hours are reduced, you may elect to continue coverage for up to 18 months for yourself, and your dependents.

FOR THE EMPLOYEE

☐ I ELECT COBRA continuation coverage for the following qualified beneficiaries who had coverage on the group health plan before the qualifying event:

☐ Medical
☐ Dental (if available)
☐ Vision (if available)
☐ Medical/Dental/Vision (if available)

Employee _____ Subscriber ID _____
Spouse _____ Date of Birth _____
Dependent _____ Date of Birth _____
Dependent _____ Date of Birth _____
(Please list additional dependents on second page)

☐ I hereby DECLINE COBRA continuation coverage under the group health plan

_____ _____
Employee Signature Date

FOR THE SPOUSE

(This form must be completed if the Employee declined coverage and the Spouse wishes to continue coverage for him/herself and/or eligible dependent children)

☐ I ELECT COBRA continuation coverage for the following qualified beneficiaries who had coverage on the group health plan before the qualifying event:

☐ Medical
☐ Dental (if available)
☐ Vision (if available)
☐ Medical/Dental/Vision (if available)

Spouse _____ Social Security No. _____
Dependent _____ Date of Birth _____
Dependent _____ Date of Birth _____

☐ I hereby DECLINE COBRA continuation coverage under the group health plan

_____ _____
Spouse Signature Date

Return this form to:
Attn: Bill Clerk _____
Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

FOR DEPENDENTS (age 18 and over)

(This form must be completed by each dependent age 18 and over if neither the employee or spouse has elected COBRA continuation coverage for the dependent(s), or if the dependent is no longer eligible for coverage as a dependent.)

☐ I ELECT COBRA continuation coverage for the following qualified beneficiaries who had coverage on the group health plan before the qualifying event:

- ☐ Medical
- ☐ Dental (if available)
- ☐ Vision (if available)
- ☐ Medical/Dental/Vision (if available)

☐ I hereby DECLINE COBRA continuation coverage under the group health plan

_____ _____ _____

Dependent Signature | Date | Subscriber ID

Additional Dependents:

Dependent _____ Date of Birth _____

Dependent _____ Date of Birth _____

Dependent _____ Date of Birth _____

Dependent _____ Date of Birth _____

Dependent _____ Date of Birth _____

Return this form to:
Attn: Bill Clerk _____
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P.O. Box 660255
Dallas, TX 75266-0255