BlueCross BlueShield of Montana

COBRA Qualifying Event Notification Form

In order to receive continuation of group health coverage benefits under the Consolidated Omnibus Budget Reconciliation Act and possibly a temporary reduction in COBRA premium payments under the recently enacted American Recovery and Reinvestment Act, a **timely notice** must be provided for each qualifying event. In some instances, COBRA may be extended by a disability or second qualifying event if timely notice is provided. **Timely notice** deadlines are listed below. **Timely notice** must be submitted to:

Blue Cross and Blue Shield of Montana
COBRA Administrator
P.O. Box 660255
Dallas, TX 75266-0255

Note: This COBRA Qualifying Event Notification form does not allow you to elect COBRA continuation coverage. The purpose of this form is to allow you to notify the COBRA Administrator for your group health plan that you have experienced a qualifying event. Within 14 days of receipt of this **COBRA Qualifying Event Notification Form**, the COBRA administrator will mail a COBRA Continuation Coverage Election Form to each qualified beneficiary. In order to elect COBRA continuation coverage, the COBRA Continuation Coverage Election Form must be returned to the COBRA administrator by the deadline specified in that form.

Covered Employee Name:	Subscriber Identification No.:	Telephone Number:	
Employee Mailing Address:	City/Town:	State:	Zip Code:
Group Health Plan:			

Part 1	**Initial COBRA Qualifying Event**	Date of Qualifying Event:

Timely Notice: Within 60 days from event date — **Responsibility for Notification:** Employee

☐	Employee's divorce or legal separation	☐	Dependent child not eligible for coverage under group health plan

Timely Notice: Within 30 days from event date — **Responsibility for Notification:** Employer

☐	Reduction in work hours	☐	Employee's death
☐	Voluntary termination	☐	Employee eligible for Medicare (allows COBRA continuation for spouse and/or dependents)
☐	Involuntary termination		
☐	Termination for gross misconduct	☐	Other:

Qualified Beneficiary(ies)

Name	Address	Subscriber ID/Plan Identification Number	Relationship to Employee

Completed by: (Printed Name) _____ Date _____

Signature _____

Part 2	**Second COBRA Qualifying Event**

If the original COBRA continuation coverage period was 18 months, the following qualifying events will extend coverage for an additional 18 months (for a total of 36 months) for the covered spouse and covered dependent children if the event would have originally caused a loss of coverage.

Timely Notice: Within 60 days from event date — **Responsibility for Notification:** Qualified Beneficiary

☐	Death of former employee	☐	Divorce or legal separation
Date of Death:		Date of divorce:	
☐	Former employee enrolls in Medicare Part A, Part B, or both	☐	Dependent child ceases to be eligible under group health plan as a dependent
Date of Medicare Eligibility:		Date of loss of eligibility:	

Qualified Beneficiary(ies)

Name	Address	Subscriber ID/Plan Identification Number	Relationship to Employee

Completed by: (Printed Name) _____ Date _____

Signature _____

Part 3A Extension Due to Medicare Disability

Applies to any qualified beneficiary determined by the Social Security Administration to be disabled prior to or at any time during the first 60 days of COBRA continuation coverage.

Timely Notice: The qualified beneficiary must notify the COBRA administrator before the end of the 18-month period of COBRA continuation coverage. COBRA continuation coverage may be extended up to an additional 11 months, for a total of 29 months.

Responsibility for Notification: Qualified Beneficiary

☐ I have enclosed a copy of the letter from SSA advising of the Disability Determination. This letter shows the effective date of the disability. (Required)

Printed Name of Disabled Qualified Beneficiary	Date of SSA Determination	Date Disability Began

Please extend COBRA continuation coverage up to an additional 11 months for the following qualified beneficiaries.

Qualified Beneficiary(ies)

Name	Address	Subscriber ID/Plan Identification Number	Relationship to Employee

Completed by: (Printed Name) _____ Date _____

Signature _____

Part 3B Determination that Qualified Beneficiary is no longer disabled.

Timely Notice: Notice must be provided within 30 days after the date of the SSA's determination that the beneficiary is no longer disabled.

Responsibility for Notification: Qualified beneficiary with disability

☐ I have enclosed a copy of the letter of the termination of SSA Disability Determination. (Required)

Note: The COBRA continuation coverage of all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA determination that the qualified beneficiary is no longer disabled.

Printed Name of Disabled Qualified Beneficiary	Date of SSA Determination	Date Disability Began

Completed by: (Printed Name) _____ Date _____

Signature _____

If you have any questions, please contact Blue Cross and Blue Shield of Montana at 1-800-447-7828.