BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

HMO Louisiana, Inc.
A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

CONTINUATION OF COVERAGE UNDER COBRA OR STATE CONTINUATION

THIS FORM IS TO BE COMPLETED BY THE EMPLOYER AND RETURNED TO:	Blue Cross and Blue Shield of Louisiana Attn: Membership and Billing Department P.O. Box 98029 Baton Rouge, LA 70898-9029 Fax Number: 225-298-2988

A completed and signed application for the **continuing** spouse or dependent must be returned to us along with this continuation of coverage form. An application is not necessary for employees continuing because of termination of employment or reduction in hours.

For State Continuation, for the surviving spouse age 50 years and older, an application must be completed, signed, dated and returned with the Continuation of Coverage form within 90 days of the employee's death.

EMPLOYER INFORMATION			
NAME OF GROUP			GROUP POLICY NO.
ADDRESS	CITY	STATE	ZIP CODE

REASON(S) FOR GROUP COVERAGE ENDING

- ❑ death of the covered employee
- ❑ termination of employment of the covered employee
- ❑ divorce of the covered employee from the employee's spouse
- ❑ reduction in employment hours (COBRA reason only)
- ❑ the covered employee's commencement of Medicare coverage (COBRA reason only)
- ❑ the end of dependent child coverage under the terms of the plan (COBRA reason only)
- ❑ employee leaving employment due to disability (COBRA reason only)

NAME OF CONTINUING EMPLOYEE, SPOUSE OR DEPENDENT			SOCIAL SECURITY NUMBER
RELATIONSHIP OF CONTINUING PERSON TO EMPLOYEE			DATE OF BIRTH
EMPLOYEE NAME			DATE GROUP COVERAGE ENDED
EMPLOYEE'S ADDRESS	CITY	STATE	ZIP CODE
DATE OF EMPLOYEE'S DEATH, OR DIVORCE DECREE DATE			CONTRACT NUMBER

Note: Please refer to your Continuation of Coverage Rights Provision Section of your policy booklet.

If applying for COBRA, coverage is limited to a maximum of 18 months. If applying for state continuation, coverage is limited to a maximum of 12 months.

EMPLOYEE/DEPENDENT(S) SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE _____ DATE _____

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company