Beneficiary Election Form to Continue Health and Vision Benefits

Anthem

Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, ME 04106

INSTRUCTIONS:

BENEFICIARY–if you want to continue coverage, please complete Sections 1 through 4 and include the first months premium with this application. If you have any questions regarding the terms of your group coverage or any other COBRA questions, please contact your benefit administrator, usually your employer. Please keep one copy for your records and return two copies to the employer before the date shown as "Eligibility expires on" in Section 5.

EMPLOYER–please complete Section 5 before mailing to the beneficiary. Please keep one copy and send one copy to Anthem Blue Cross and Blue Shield.

Reset Form | Save and Print Form

SECTION 1: BENEFICIARY INFORMATION

Last name	First name			Daytime phone
Address	City	State	ZIP code	Email address

If you are a dependent of an employee/former employee, please complete the following

Last name	First name	M.I.	Employee certificate no.	Relationship to employee ☐ Spouse ☐ Son ☐ Daughter ☐ Other_____

SECTION 2: FAMILY INFORMATION – List all family members whose coverage you want to continue

Note: Dependents who are eligible to make independent elections under COBRA and wish to do so, must complete separate election forms. You may cover only members who were covered under your group program.

Health	Vision	Last name	First name	Sex	Social security no.	Birthdate MM/DD/YY	Relationship to Employee
☐	☐			☐ M ☐ F			☐ Self ☐ Child ☐ Spouse
☐	☐			☐ M ☐ F			☐ Self ☐ Child ☐ Spouse
☐	☐			☐ M ☐ F			☐ Self ☐ Child ☐ Spouse

SECTION 3: TO CONTINUE COVERAGE – Complete this section

I am requesting coverage for myself and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage. I understand that each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Certificate of Coverage.

Applicant signature **X**	Date

SECTION 4: IF YOU DO NOT WANT TO CONTINUE COVERAGE – Complete this section

I have read this form and the notice of rights. I do not want to continue coverage under the COBRA plan because ☐ I have other coverage ☐ I am moving out-of-state

Beneficiary signature **X**	Date

SECTION 5: EMPLOYER USE ONLY – Please complete before mailing to the beneficiary

Employer name			Group no.
Employer address	City	State	ZIP code
Beneficiary name (member or dependent losing coverage)	Date of qualifying event		Certificate no.

Continued coverage date (Termination date of insurance)	Date eligibility expires (60 days for loss of coverage due to the event)	Group Rates Health $_____	Vision $_____

Qualifying event (reason for continuation) - Will be billed at 102% of Group Rate

☐ Surviving spouse/dependent ☐ Employee on Medicare ☐ Dependent child ☐ Employer filed bankruptcy
☐ Termination or reduction of employee's hours ☐ Divorced spouse ☐ Voluntary ☐ Involuntary

Date sent to the beneficiary

If you are interested in receiving information on our individual health insurance plans, please call 1-800-585-0099 or, if in greater Portland area, 822-7878.