How to Apply for COBRA Coverage

If you or your dependents are eligible and wish to apply for COBRA coverage:

1 Complete and sign the attached COBRA coverage application. Make sure that you've included the names and birth dates of each of your dependents to be covered under COBRA coverage. Include your Social Security number.

2 Obtain the applicable Health Plan dues rate from your personnel or human resources department.

Completing Your Application for Enrollment

1 Please complete all items requested.

2 Please be sure to list all family members to be covered under COBRA coverage. To be eligible for COBRA coverage, a dependent must have been covered under your group plan.

3 Please remember to include your Social Security number and your birth date in the "About You" section, and the birth dates of each of your dependents in the "About Your Family" section.

4 Please be sure to include your signature at the bottom of the application.

5 Please return the completed application to your personnel or human resources department.

6 Retain the last copy for your records.

Coverage

Your benefits with continuation coverage will be identical to your present benefits and are subject to change if the group coverage changes. COBRA coverage begins when your group coverage ends.

▶

Continuation of Group Coverage

The federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires employers of 20 or more employees (except church employers) to provide a continuation of group coverage to employees and dependents who would normally lose group coverage. COBRA requires that employers notify the qualifying person about the right to continue coverage when loss of group eligibility occurs. Cost is to be paid entirely by you. Your employer is not obligated to contribute toward the cost of the plan. You and your dependents may be eligible to receive uninterrupted COBRA coverage if you are a qualified beneficiary as defined below.

COBRA coverage is available for up to **18 months** *to:*

- A subscriber and dependents, when the subscriber loses employment with the group through which he/she is enrolled for reasons other than gross misconduct;
- A subscriber and dependents, when the subscriber's hours are reduced and he/she no longer qualifies for group coverage.

COBRA coverage is available for up to **29 months** *to:*

- An employee or qualified beneficiary who is determined to have been disabled for Social Security purposes at the time of the termination of employment or reduction in hours, and who gives the group notice of such determination within 60 days and before the end of the 18-month continuation period. The disability extension provision is effective regardless of when the qualifying event occurred.

COBRA coverage is available for up to **36 months** *to:*

- A qualified beneficiary who loses group membership because of divorce or legal separation;
- A qualified beneficiary who loses group membership due to the death of the subscriber;
- A dependent child who marries or reaches the age limit for group membership, or experiences a change in custody;
- A dependent when a subscriber becomes entitled to Medicare benefits;
- Employees of a group that files Chapter 11 bankruptcy.

40-538-97/E9508–3M

Your Application for COBRA Enrollment

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
California Service Center
California Division

Your Application for COBRA Enrollment

About You (Subscriber)

Please print firmly. Please complete all items requested.

Last Name	First Name	Initial	Current Group Number	COBRACoverage Start Date (Mo Day Yr)
			—	

Check One: ❏ Male ❏ Female	Birth Date (Mo Day Yr)	Your Social Security Number	Family Account Number	Medical Record Number

Your Employee Payroll Number	Qualifying Employer (Company Name)	Employer Address/City/State/Zip Code

Reason for COBRA Coverage Request

❏ Termination of Employment (Up to 18 Months Coverage)	Last Date Employed (Mo Day Yr)	❏ Disabled for Social Security purposes (Up to 29 Months	Group Coverage Ends on (Mo Day Yr)
❏ Loss of Dependent Status Due to ▶ (Up to 36 Months Coverage)	❏ Marriage ❏ Divorce ❏ Death of subscriber ❏ Reached maximum age limit	❏ Other: (Describe)	Divorced or Left School on (Mo Day Yr)

Your Address Number/Street	Apt. Number	City/State/Zip Code

Daytime Phone Number	Marital Status	Were you or any family members listed on this form previous Kaiser Permanente members in Southern California?
( )	❏ Single ❏ Married ❏ Divorced ❏ Separated ❏ Widowed	❏ Yes ❏ No

IF YES, through which Group/Company?	Last month and year of previous membership (Mo Yr)	In Whose Name:	Previous Medical Record Number(s), if known

Office Use Only ▶

Process Month or Receipt Date	
RSN	COBRAElig.
Medical Record Number	

About Your Family

Please list below eligible dependents you wish to have enrolled under COBRAcoverage. You may include only your spouse and any unmarried dependent children. Please remember to include the birth date of each of your dependents.

Spouse (Last Name)	**First Name**	**M.I.**	**Sex**	**Relationship to Subscriber**	**Other (Specify)**	**Birth Date** (Mo. Day Yr.)	**RSN**	**Med. Rec.**	**Med. Dep.**
			❏ Male ❏ Female	❏ Husband ❏ Wife					
Child			❏ Male ❏ Female	❏ Son ❏ Daughter					
Child			❏ Male ❏ Female	❏ Son ❏ Daughter					
Child			❏ Male ❏ Female	❏ Son ❏ Daughter					
Child			❏ Male ❏ Female	❏ Son ❏ Daughter					
Child			❏ Male ❏ Female	❏ Son ❏ Daughter					
Child			❏ Male ❏ Female	❏ Son ❏ Daughter					

I understand, except for small claims court cases, any claim that I, my heirs, or other claimants associated with me, assert for alleged violation of any duty arising out of or relating to membership in Health Plan (which provides HMO and In-Network Point-of-Service benefits), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision does not apply to disputes with Kaiser Permanente Insurance Company or disputes arising from Out-of-Network services. Note: A different arbitration provision applies for Federal Employees Health Benefits Program and CalPERS groups. Please contact Member Services for the applicable arbitration provision.

Your Signatur e ______________________ Date ______________

Top copy–To Membership Accounting **Middle copy**–To be retained by the group **Bottom copy**–To be retained by the subscriber