

Commonwealth of Virginia Health Benefits Program

Extended Coverage/COBRA Enrollment Form

Extended Coverage /COBRA participants/qualified beneficiaries should use this form to enroll or make allowable changes to their health plan coverage. Refer to your Election Notice for information regarding your Extended Coverage/COBRA rights and responsibilities.

PART A: Enrollee Information

PLEASE PRINT

Name _____ Social Security Number _____ - _____ - _____
First Name M.I. Last Name

Address _____
Street City State Zip + 4

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex: Male Female Date of Birth _____
MM/DD/YYYY

PART B: Initial Enrollment

Qualifying Event (Check one)

- | | | |
|--|--|--|
| <input type="checkbox"/> Termination of Employment | <input type="checkbox"/> Reduction in Hours (includes leave without pay and VSDP long-term disability) | <input type="checkbox"/> Loss of Dependent Child Eligibility |
| <input type="checkbox"/> Divorce | | <input type="checkbox"/> Death of the Employee |
| Date Of Qualifying Event _____ | | <input type="checkbox"/> Military Leave |

For initial enrollment, return this Enrollment Form, your Election Form and Request for Treatment as an Assistance Eligible Individual, if applicable, (included with your Election Notice) to the address provided in your Election Notice.

PART C: Requesting Changes To Membership

Once enrolled, you may change your plan and/or type of membership during the annual Open Enrollment (non-Medicare plans only) or within 31 days of a consistent qualifying mid-year event which permits an election change.

Reason for Change:

- Open Enrollment Change**
 Qualifying Mid-Year Event

Indicate reason for the membership change from the list of events below, and attach documentation to support the event.

Date of event: _____
Month/Day/Year

- | | |
|---|--|
| <input type="checkbox"/> Birth or adoption (15) | <input type="checkbox"/> Marriage (07) |
| <input type="checkbox"/> Change from full-time to part-time employment (77) | <input type="checkbox"/> Permanent custody of a child (72) |
| <input type="checkbox"/> Change from part-time to full-time employment (78) | <input type="checkbox"/> Unpaid leave for spouse (64) |
| <input type="checkbox"/> Death of child (17) | <input type="checkbox"/> Unpaid leave ended for spouse (63) |
| <input type="checkbox"/> Death of spouse (08) | <input type="checkbox"/> Child ceases to be eligible/second qualifying event (38)* |
| <input type="checkbox"/> Gained entitlement to Medicaid (66) | <input type="checkbox"/> Divorce/second qualifying event* |
| <input type="checkbox"/> Judgment, decree or order to add child (71) | <input type="checkbox"/> Enrolled in other group health plan coverage* |
| <input type="checkbox"/> Judgment, decree or order to remove child (67) | <input type="checkbox"/> Gained entitlement to Medicare (66)* |
| <input type="checkbox"/> Lost another government-sponsored plan (76) | <input type="checkbox"/> Determined disabled by Social Security Administration* |
| <input type="checkbox"/> Lost employer eligibility (13) | <input type="checkbox"/> Ceased to be disabled during disability extension* |
| <input type="checkbox"/> Lost Medicare or Medicaid (09) | <input type="checkbox"/> Death of former employee/second qualifying event* |
| <input type="checkbox"/> HIPAA Special Enrollment | <input type="checkbox"/> Move affecting eligibility health plan coverage |

* See your Election Notice for additional information regarding these events

Dependent(s) affected: _____

- Terminate Extended Coverage/COBRA for:** _____
(To terminate coverage for all family members, you may just stop paying your monthly premium.)

To request this change, return this Enrollment Form to the Office of Health Benefits Extended Coverage/COBRA Administration at 101 North 14th Street, 13th Floor, Richmond, VA 23219.

PART D: Health Coverage

I. TYPE OF MEMBERSHIP REQUESTED (Check one and list in Section III. below)

Single
 Enrollee Plus One
 Family
 Is this a change in membership?
 Yes
 No

II. HEALTH PLAN

- | | |
|---|--|
| <input type="checkbox"/> COVA Care* (with basic dental) (ACC0) | <input type="checkbox"/> COVA Connect** (with basic dental) (OCC0) |
| <input type="checkbox"/> COVA Care + Out-of-Network (ACC1) | <input type="checkbox"/> COVA Connect + Out-of-Network (OCC1) |
| <input type="checkbox"/> COVA Care + Expanded Dental (ACC2) | <input type="checkbox"/> COVA Connect + Expanded Dental (OCC2) |
| <input type="checkbox"/> COVA Care + Out-of-Network + Expanded Dental (ACC3) | <input type="checkbox"/> COVA Connect + Out-of-Network + Expanded Dental (OCC3) |
| <input type="checkbox"/> COVA Care + Expanded Dental + Vision & Hearing (ACC4) | <input type="checkbox"/> COVA Connect + Expanded Dental + Vision & Hearing (OCC4) |
| <input type="checkbox"/> COVA Care + Out-of-Network + Expanded Dental + Vision & Hearing (ACC5) | <input type="checkbox"/> COVA Connect + Out-of-Network + Expanded Dental + Vision & Hearing (OCC5) |

- | | |
|--|---|
| <input type="checkbox"/> COVA HDHP–High Deductible Health Plan (CHD) | <input type="checkbox"/> Kaiser Permanente HMO – available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP) |
|--|---|

* Available in all areas except designated Hampton Roads zip codes **Available in designated Hampton Roads zip codes

III. FAMILY MEMBERS TO BE COVERED (list all)

Type of Qualifying Beneficiary (QB): H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF= other female child* OM=other male child*

NAME PLEASE PRINT (include last name if different)	BIRTHDATE MM/DD/YYYY	SOCIAL SECURITY NUMBER	QB TYPE (SEE ABOVE)
Spouse			
Children			

If you need more space, list additional children on a separate sheet of paper and attach to this Form.

*Attach explanation. Eligibility must be verified by your Benefits Administrator.

PART E: Certification

ENROLLEE STATEMENT: I want to enroll or make a change in Extended Coverage/COBRA. I understand that I will be billed directly for the monthly premium. Once enrolled, I understand that changes may only be made at Open Enrollment or with certain qualifying mid-year events (see Part C) when the changes are consistent with the events. I have read and understand my rights and responsibilities as explained in my Election Notice. I understand that my premiums are subject to change and that the Commonwealth of Virginia reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability just as those requirements apply to similarly-situated non-Extended Coverage health plan participants. I understand that non-payment of premium will result in cancellation of coverage per the provisions of the Public Health Service Act as described in my Election Notice and that claims will not be processed during the defined grace period. Further, I understand that no claims will be processed for services during months for which premium payment in full has not been received.

CERTIFICATION/AUTHORIZATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name _____ Social Security Number _____

Sign Here _____ Date _____

Agency Approval/Verification For Initial Enrollment

Number of months for Extended Coverage: _____

I certify that I have reviewed this Extended Coverage Enrollment Form and that it is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date Received _____
MM/DD/YYYY

Print Name and Title _____ Phone No. _____

Agency Name _____ Agency No. _____ Effective Date _____
MM/DD/YYYY