CBIA Federal COBRA or State Continuation Services

CONTINUANT TAKEOVER FORM

APPENDIX A

(To transfer current Federal COBRA or State Continuation continuants to CBIA)

INSTRUCTIONS: ***Please print clearly***

- Fill out just one form per family unit (Qualified Beneficiary and Dependents)
- Please do not use this form to report new Qualifying Events — use the Federal COBRA or State Continuation Qualifying Events Form.
- Please see back side of this form for further instructions.

COMPLETE THIS FORM AND RETURN IT TO:

CBIA Insurance Operations
350 Church Street
Hartford, CT 06103-1126
Fax: 860.278.0883

PLEASE CHECK ONE BOX: ❒ **Original notice** *(If FAXED, do not mail copy)* ❒ **Revision**... *to a form that was previously sent*

1) From: (Company)

2) CBIA Case Number

3) Please be advised that the following is currently on Federal COBRA or State Continuation. (Check one box only) ❒ Employee ❒ Dependent

4) Social Security Number of Qualified Beneficiary ___ ___ ___ ___ ___ ___ ___ ___ ___

5a) Name of Federal COBRA or State Continuation continuant (last, first, mi) (Please print)

5b) Street Address **5c)** City **5d)** State **5e)** ZIP Code

6) Home Phone # (if available) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

7) Date of Birth of Qualified Beneficiary ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

8) Gender ❒ Male ❒ Female

9) Marital Status (check one box only.)
❒ Single ❒ Married ❒ Civil Union ❒ Divorced

10) If the above individual in box #5 is a dependent of an employee/former employee, please complete the following:
Employee Name (last, first, mi) ______________________________
Employee SSN ___ ___ ___ ___ ___ ___ ___ ___ ___
Dependent's relationship to Employee ______________________________

11) Qualifying Event Date ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

12) Last day of continuation coverage (cannot be prior to Qualifying Event Date)
___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

13) Qualifying Event that caused loss of coverage (check one)

❒ Employee's termination of employment (includes voluntary resignation, involuntary termination (except when due to gross misconduct), retirement, layoff, or leave of absence)
❒ Employee's reduction in work hours (includes work stoppage or strike)
❒ Death of covered employee/retiree
❒ Divorce/legal separation
❒ Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage
❒ Ineligibility of dependent child
❒ Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy) United States Code

14) Check the current plan code coverages. CBIA administers only plan code coverage options that are permitted by your plan or carrier.
(check one box only.)
❒ Employee ❒ Employee + Spouse
❒ Employee + Child(ren) ❒ Family

15) At the time of the termination or reduction in hours, was the employee eligible to receive Social Security income? ❒ No ❒ Yes

16) If the Federal COBRA or State Continuation continuant has dependents covered, please complete the following. (Please print)

Dependent Name (first, last, mi) ______________________________
Birth Date: Mo. __________ Day __________ Yr. ______
Gender (check one) ❒ Male ❒ Female
Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___
Relationship to employee__________________ Qualified Beneficiary ❒

Dependent Name (first, last, mi) ______________________________
Birth Date: Mo. __________ Day __________ Yr. ______
Gender (check one) ❒ Male ❒ Female
Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___
Relationship to employee__________________ Qualified Beneficiary ❒

Dependent Name (first, last, mi) ______________________________
Birth Date: Mo. __________ Day __________ Yr. ______
Gender (check one) ❒ Male ❒ Female
Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___
Relationship to employee__________________ Qualified Beneficiary ❒

Form completed by: Date __________
Name (print) ______________________________
Phone ______________________ Fax ______________________

TRANSFERRING CURRENT COBRA/STATE CONTINUANTS TO

CBIA Federal COBRA or State Continuation Services

Instructions for completing Continuant Takeover Form (on reverse side)
(use one form per family unit)

This form is only needed if you have current Federal COBRA or State Continuants to be transferred to CBIA Service Corp. Federal COBRA or State Continuation Services.
One form should be completed for each family unit and sent to:

CBIA Insurance Operations
350 Church Street, Hartford, CT 06103-1126

SECTION 1:
Enter your company name.

SECTION 2:
Enter your CBIA Case number.

SECTION 3:
Check appropriate box to indicate whether Continuant is an employee or dependent. (Check one box only.)

SECTION 4:
Enter the Continuant's complete nine-digit Social Security number.

SECTION 5:
Enter Continuant's complete name (last, first, middle initial) and complete mailing address (street, city, state and ZIP Code.)

SECTION 6:
Enter Continuant's home phone number, including area code, if available.

SECTION 7:
Continuant's date of birth. (month, day, year)

SECTION 8:
Check appropriate box to indicate the Continuant's gender (Male or Female)

SECTION 9:
Check appropriate box to indicate marital status of Continuant.

SECTION 10:
If the Continuants is a dependent of an employee or former employee, enter employee's complete name (last, first, middle initial), employee's nine-digit Social Security Number and Continuant's relationship to employee.

SECTION 11:
Enter the month, day and year of the Qualifying Event.

SECTION 12:
Enter the LAST DAY (month, day, year) of the Continuant's pre-Federal COBRA or State Continuation of Coverage.

SECTION 13:
Check appropriate box (check one box only) to indicate the type of Qualifying Event. "Employee's termination of employment" includes voluntary resignation, involuntary termination (except for termination due to gross misconduct), retirement, layoff, or leave of absence. Employee's reduction in hours includes work stoppage (strike)."

SECTION 14:
Indicate coverage by checking the box of the appropriate plan code.

SECTION 15:

Check appropriate box (Yes or No) to indicate whether at the time of the termination or reduction in hours, the employee was eligible to receive Social Security income.

SECTION 16:
Provide information if the Continuant has dependents covered, and indicate whether the individual is a Qualified Beneficiary and was covered under the group health plan at the time of the original Qualifying Event or was born to or placed for adoption with a covered employee during the period of Federal COBRA or State Continuation coverage.

PLEASE BE SURE TO COMPLETE ALL ITEMS AND TO SIGN AND DATE FORM. INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.