



Please check your previous plan below:

NationCare

PO BOX 30192 • SALT LAKE CITY • UTAH 84130-0192 • Tel: 1-801-442-5038 • Toll Free: 1-800-538-5038

* Eligibility is administered by SelectHealth and underwritten (insured) by Guarantee Trust Life Insurance Company, Inc. (GTL).

NationCare COBRA Form (See reverse side for instructions)

Qualified Beneficiary (QB)

Employer Name _____
Name (Last, First, Middle Initial) _____ Social Security# _____
Street _____ City _____ State _____ ZIP Code _____ Work Phone# _____
Marital Status Single Married Divorced Widowed Separated Sex Male Female Home Phone# _____

EMPLOYEE INFORMATION

If you are not the employee, please complete the name, Social Security#, and your relationship to the employee under whom you were previously covered.

Employee Name Last _____ First _____ Middle Initial _____ Social Security# _____

Your relationship to employee Spouse Dependent

COVERAGE INFORMATION

Complete the following information in full. List yourself and all eligible dependents (spouse and children) you wish to be covered. Children must be unmarried and dependent upon you for their support. Children should be listed in order of age. **List relationship of children** as son/daughter; step son/step daughter. Please use one line per individual. If you need additional space, use another COBRA form. Additional copies of this form are available from SelectHealthSM. Any dependents not listed will not be covered.

NOTE: You may elect to continue only those benefits for which you were enrolled before the qualifying event for yourself and any eligible dependents.

	NAME OF MEMBER TO BE COVERED (LAST, FIRST, MIDDLE INITIAL)	SEX M F	BIRTH DATE (MM/DD/YY)	RELATIONSHIP	SOCIAL SECURITY#
1	Yourself				
2					
3					
4					
5					
6					

Is your ex-spouse required to pay your dependent's medical expenses in a divorce decree? Yes No

If yes, you must attach a copy of the divorce decree with this form. You should include the first page of the decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage.

Will you have other health insurance? Yes No (If yes, complete the information below.)

	MEMBER TO BE COVERED	CARRIER	PHONE#	POLICY EFFECTIVE DATE	POLICYHOLDER NAME
1					
2					
3					

SIGNATURE

I hereby apply for membership under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and make such application for the persons listed on this application (herein referred to as applicants) and agree to submit to the employer through whom I have been offered this coverage prepayment fees as required by GTL. I understand the initial prepayment fees must be received within 45 days of this election. I understand that if I fail to make my monthly payments in accordance with the rules set forth by the employer group, my coverage will cease as of the end of the period for which payment was made and cannot be reinstated. I accept the terms of the group agreement between the employer and GTL. I understand that said agreement is on file with the employer and GTL and is available for my inspection. I understand that misrepresentation in answering the questions on this application or nonpayment of prepayment fees, coinsurance, or copays may result in rescission or cancellation of my coverage and that of my dependents. I understand that the length of time that I may be covered will depend on the nature of the qualifying event, which qualified me for coverage, and that my benefits may be affected by changes in the employer's group plan.

I represent that the information on this form is true. I understand that no agent or GTL representative is allowed to permit me to answer any questions inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to GTL any change in the eligibility of any applicants who become members.

I agree that any claim or dispute, including claims for bodily injury or death of a member, asserted by a member, his or her dependents, assigns, heirs, or personal representative, against the plan, its employees or contracting medical groups, health professionals, pharmacies, hospitals, or their employees, is subject to binding arbitration. This provision does not preclude any dispute resolution by any small claims court having jurisdiction.

Employee Signature _____ Date _____

EMPLOYER SECTION

Qualifying Event Information

The employee is eligible for continuation or health coverage due to (check one):

- Employee termination
- Reduction in working hours of employee
- Death of the employee Mo. ____ Day ____ Yr. ____
- Employee became eligible for Medicare Mo. ____ Day ____ Yr. ____
- Divorce or annulment Mo. ____ Day ____ Yr. ____
- Dependent no longer meets eligibility requirements Mo. ____ Day ____ Yr. ____
- New COBRA plan with GTL
- Transfer from previous carrier's coverage (If coming from previous carrier COBRA plan, please specify qualifying event information and coverage period information.)

Coverage Period Information

____/____/____
Date of Qualifying Event

Qualifying Event Coverage Period

- 18 Months
 - 36 Months
- ____/____/____
Date COBRA Expires

Extension Of Coverage

Length of Extension _____ months
Date COBRA Started _____
Date COBRA Expires _____
Reason for Extension _____

Note: If you are extending coverage because of a disability, you must attach a copy of the Social Security Administration Determination Letter with this form.

Last Day of Regular Group Coverage _____ Effective Date _____ Company Number _____

Comments _____

Employer Approval _____ Date _____

COBRA Form Instructions

All areas are to be completed in detail by you and/or the employer. It is your responsibility to read and understand this information and follow the instructions given. Please print clearly. Application and forms that are illegible or incomplete will be delayed.

The following instructions will usually answer any questions that you may have. If you need more help, contact a Human Resources/Personnel representative at the employer through whom you are receiving coverage or SelectHealth Member Services at 1-801-442-5038 (Salt Lake area) or 1-800-538-5038.

- 1. Qualified Beneficiary Information** - Complete this section with information about the Qualified Beneficiary.
- 2. Employee Information** - Complete the employee information. If you are not the employee, you must complete the name, Social Security number, and your relationship to the employee.
- 3. Coverage Information** - Individually list those persons for whom you wish coverage.
- 4. Signature** - Please read the information in this section carefully. Sign and date to complete this form.
- 5. Employer Section** - An authorized representative of the employer group should complete this section.

NOTE: *A change form indicating plan member(s) termination from regular group coverage must precede or accompany submission of this form to the Plan.*

- Qualifying Event Information - Indicate the reason for this continuation coverage.
- Coverage Period Information - Enter the date of the qualifying event, and mark the box for the qualifying event coverage period. Also mark the date that COBRA expires.
- Extension of Coverage - Complete the length of extension, the beginning and ending dates of COBRA coverage, and the reason for the extension.
- Effective date is the exact date coverage is to begin.
- The Company Number is assigned by your employer. If the employer group is new to NationCare, leave this space blank, and the number will be assigned. If the employer group has previously been assigned a number by your employer, write that number in the space provided (See left corner of billing invoice for Company Number.)
- The "comments" section may be used to communicate miscellaneous information to SelectHealth.
- The signature of the employer's representative and the date signed must be completed to validate the application. Such employer approval also indicates your agreement to pay all prepayment fees as required by GTL.