

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 n

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.

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 <small>Mo Day Yr</small>		
Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date <small>Mo Day Yr</small>		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	<input type="checkbox"/> Termination of Employment (Up to 18 Months Coverage)		Last Date Employed <small>Mo Day Yr</small>		<input type="checkbox"/> Disabled for Social Security purposes (Up to 29 Months)		Group Coverage Ends on <small>Mo Day Yr</small>		
	<input type="checkbox"/> Loss of Dependent Status Due to (Up to 36 Months Coverage)		<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death of subscriber <input type="checkbox"/> Reached maximum age limit		<input type="checkbox"/> Other: (Describe)		Divorced or Left School on <small>Mo Day Yr</small>		
Your Address		Number/Street		Apt. Number	City/State/Zip Code				
Daytime Phone Number ()		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Were you or any family members listed on this form previous Kaiser Permanente members in Southern California? <input type="checkbox"/> Yes <input type="checkbox"/> No				
IF YES, through which Group/Company?		Last month and year of previous membership <small>Mo Yr</small>		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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Subscriber <input type="checkbox"/> Husband <input type="checkbox"/> Wife	Other (Specify)	Birth Date <small>Mo Day Yr</small>	RSN	Med. Rec.	Med. Dep.
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Son <input type="checkbox"/> 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 Signature _____ Date _____