## Read Carefully

# **Notice** (Involuntary Termination of Employment)

## Election to Continue Coverage Under Nebraska Law (Employers that are not subject to COBRA[1])

Neb. Rev. Stat. §§ 44-1640 through 1642 (R.R.S. 2004) requires your employer to provide notice that you, as an employee involuntarily terminated[2] for reasons other than misconduct in connection with your employment, may be entitled to continue your health coverage by paying the applicable premium, at 102% of the group's rate[3] (if applicable), on a monthly renewal basis until the earliest of the following dates:

(1) Six months from the date your coverage would otherwise be terminated;

(2) The date you become eligible for other group hospital, surgical or medical coverage, or Medicare;

(3) If premiums are not paid, at the end of the monthly period for which premiums are paid;

(4) The date of termination of the group contract.

**To elect this coverage, you must return the election form and the first monthly premium,** in the form of a check - alternative forms of payment will not be accepted, **by CERTIFIED MAIL** with return receipt requested to Blue Cross and Blue Shield of Nebraska (BCBSNE), **within 10 days** after the date of receipt of this Notice.

You may decline coverage for yourself while electing coverage for your family members.

By electing coverage, you will receive the bills for your premium at the address you provide on the form. Premiums are billed at 102% of the group's rate (if applicable). The full amount must be paid in order to maintain coverage. Such premiums must be accompanied by your BCBSNE member ID number.

Premiums for each subsequent month shall be paid by the terminated employee without further notice. Payment is due on the first of the month and is delinquent after the 10th day of the month. Payment must be posted to your account to avoid termination of coverage by the contract grace period.

Mail the election form and your first month's premium to:

Blue Cross and Blue Shield of Nebraska
PO Box 2638
Omaha, NE 68103

[1] Public Law 99-272 (COBRA) and subsequent amendments and regulations.

[2] The interruption of employment due to labor dispute shall not be considered to be an involuntary termination.

[3] 102% premium rating aligns with regulations concerning COBRA and State Continuation.

BlueCross BlueShield Nebraska

# Nebraska State Law - Notice and Election to Continue Coverage

(Involuntary Termination of Employment) 6-Month Extension

**PLEASE PRINT.**
1. Employer - complete sections 1. and 3.(a). Retain a copy and provide original to Employee.
2. Employee - review all provisions, sign sections 2. and 3.(b). Retain a copy and return original as indicated below.

Employee should send this form to: Blue Cross and Blue Shield of Nebraska
PO Box 2638
Omaha, NE 68103

**1.** Name of Employer | Group Number

Name of Covered Employee/Subscriber | BCBSNE ID Number (Covered Employee)

Address of Employee

Date of Termination | Last Day of Group Coverage | Date Notice is Sent

**Monthly Premium** (Premium amounts should reflect 102% of your group member premium - if applicable)

Family $_____ Employee+Spouse $_____ Employee Only $ _____ Employee+Child(ren) $_____

## 2. Electing Coverage: In order to continue your group coverage, complete sections 2 and 3(b); date and sign.

**I hereby apply for:** ☐ Family ☐ Employee+Spouse ☐ Employee Only ☐ Employee+Child(ren)

Are you or members of your family covered by any other group health plan? ☐ Yes ☐ No If yes, please complete the following:

| Group Policyholder | Insurance Company and Address | Policy ID #[4] / Effective Date | Contract Status |
|---|---|---|---|
| | | | ☐ Family ☐ Employee-Spouse ☐ Employee Only ☐ Employee+Child(ren) |

Is there any Medicare (aged or disability) coverage on you or members of your family? ☐ Yes ☐ No

If yes, indicate member name _____

Election: I, the undersigned, do elect to continue my insurance coverage with Blue Cross and Blue Shield of Nebraska in accordance with the requirements of Neb. Rev. Stat. §§ 44-1640 through 1645. State Continuation premium statements will be provided by Blue Cross Blue Shield of Nebraska each month for the duration of coverage. ***I understand I must pay future premiums, which will be at 102% of my group's current premium amount (if applicable), without further notice within the month they are due or 31 days from the due date.*** I agree to provide all information necessary to determine whether I am entitled to and have made a valid election of this coverage, and hereby verify that all information provided on this form is true and complete.

**I authorize Blue Cross and Blue Shield of Nebraska to obtain or release medical information to the extent necessary for processing claims for myself and/or my dependents.**

Date _____ Employee Signature _____

[4] If the elected State Continuation coverage is solely for your family members and you are excluded from coverage, your BCBSNE member ID number will change.

## 3. Delivery and Return:

(a) Employer/Method of Delivery of Notice/Election to Employee:
Certified Mail with return receipt requested
Initials _____ Date _____

(b) Employee Election/Indicate Method of Return and Date:
Certified with return receipt requested to Blue Cross and Blue Shield of Nebraska
Initials _____ Date _____

(c) Date received by Blue Cross and Blue Shield of Nebraska _____