



# BlueCross BlueShield of Mississippi

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company,  
is an independent licensee of the Blue Cross and Blue Shield Association.

## STATE OF MISSISSIPPI CONTINUATION COVERAGE

THIS FORM MUST BE COMPLETED BY THE EMPLOYER AND THE EMPLOYEE.

EMPLOYER		
NAME OF GROUP	NUMBER OF EMPLOYEES (full and part-time)	GROUP POLICY NO.
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE	DATE EMPLOYEE'S GROUP COVERAGE WILL END	
MONTHLY PREMIUM FOR EMPLOYEE (Single Coverage)	MONTHLY PREMIUM FOR EMPLOYEE AND DEPENDENT(S) (Family, Employee/Spouse, Employee/Children or Two-Party)	DAY OF MONTH PREMIUM IS DUE

The Employer must complete the above section of this form. Indicate the appropriate monthly premium and the day of the month each premium payment is due in the areas provided for that information. Sign and date where indicated below. Keep a copy for your file and give this original to the Employee who is terminating.

**I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS AS SET FORTH ON BOTH SIDES OF THIS FORM.**

X \_\_\_\_\_  
EMPLOYER SIGNATURE DATE

EMPLOYEE			
EMPLOYEE NAME	EMPLOYEE PHONE#	SUBSCRIBER ID#	
ADDRESS	CITY	STATE	ZIP CODE
NAME(S) OF CONTINUING DEPENDENTS		RELATIONSHIP TO EMPLOYEE	

Subject to the provision of your group's health plan and those outlined on the back of this form, you and/or your dependents who were covered on the date your coverage ended under the health plan may be eligible for up to 12 months of continuation coverage under the group health plan.

The Employee must complete the above section of this form. Sign and date where indicated below. Send this form and a check for the first month's premium in the amount indicated to the following address on or before the date that Employee's coverage will end under the group plan.

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company  
ATTN: Individual Subscriber Accounts  
P.O. Box 1043  
Jackson, MS 39215-1043

**I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS AS SET FORTH ON BOTH SIDES OF THIS FORM. I FURTHER UNDERSTAND THAT MY MONTHLY PREMIUM RATE, AS INDICATED ABOVE, IS PAYABLE DIRECTLY TO BLUE CROSS & BLUE SHIELD OF MISSISSIPPI ON THE DAY ALSO INDICATED ABOVE . IF IS NOT RECEIVED BY THAT DATE, MY COVERAGE WILL BE TERMINATED. I UNDERSTAND THAT MY COVERAGE WILL TERMINATE IF THE EMPLOYER'S GROUP COVERAGE TERMINATES AND THAT MY PREMIUM AMOUNT AND AVAILABLE BENEFITS WILL BE ADJUSTED IF MY EMPLOYER'S GROUP COVERAGE PREMIUM OR BENEFITS ARE ADJUSTED.**

X \_\_\_\_\_  
EMPLOYEE SIGNATURE DATE

# STATE OF MISSISSIPPI CONTINUATION COVERAGE

## TERMS AND CONDITIONS

Continuation Coverage under Mississippi State law is not available to any Employee or Dependent under the following circumstances:

1. The individual is not covered under the Employer's Plan on the date of the Employee's termination and has not been continuously covered under the Employer's group plan for at least three (3) consecutive months prior to the date of termination of coverage under the Employer's Plan;
2. The individual is or could be eligible for other group coverage within 31 days after coverage under this Employer Plan ends;
3. The Employer's Plan coverage terminated due to fraud;
4. The individual failed to pay required contribution for coverage under the Employer's group plan;
5. The individual is eligible for continuation coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985;
6. The individual is entitled to Medicare benefits.

Continuation Coverage under Mississippi State law shall terminate for any person on the earliest of the following dates:

1. Twelve (12) months after the date the individual's coverage would have ended because of termination of the employment;
2. The last date for which the individual's required premium provided coverage;
3. The date the individual becomes or is eligible to become covered for similar benefits under any arrangement of group coverage;
4. The date of which the Employer group plan is terminated;
5. The date of which the individual legally resides outside of the service area of an Employer's Health Maintenance Organization group plan;
6. The date a surviving spouse or former spouse of an individual remarries and becomes covered under a group health plan that does not exclude coverage for preexisting conditions;
7. The date the individual becomes entitled to benefits under Medicare.

Continuation Coverage under Mississippi law shall be separately available to dependent spouses and children of the Employee under the following circumstances:

1. In the event the Employee is deceased, written notice of the employee's death must be provided to Blue Cross & Blue Shield of Mississippi. Within 14 days of receiving notification of the death, BCBSMS shall provide notice of the continuation privilege to the dependent spouse or the dependent children (or legal representatives of the dependent children). The dependent spouse or the dependent child has 30 days after receiving notice from BCBSMS to elect continuation coverage under the Benefit Plan.
2. In the a covered dependent child of the Employee ceases to be an eligible dependent, written notice of the date the dependent child ceased to be an eligible dependent must be provided to BCBSMS. Within 14 days of receiving notification, BCBSMS shall provide notice of continuation privilege to the dependent child. The dependent child has 30 days after receiving notice from BCBSMS to elect continuation coverage under the benefit plan.
3. In the event of Employee's divorce from his or her dependent spouse, written notice of the date of the final divorce decree shall be provided to BCBSMS. Within 14 days of receiving notification, BCBSMS shall provide notice of continuation privilege to the spouse. The spouse has 30 days after receiving notice from BCBSMS to elect continuation coverage under the benefit plan.
4. A dependent spouse and/or child who qualifies may elect continuation coverage for a period not to exceed 12 months after:
  - A. The date of the death of the Employee
  - B. The date of the spouse's divorce from the Employee
  - C. The date the Employee became covered under Medicare
  - D. The date the dependent child ceases to be an eligible dependent of the Employee

A dependent spouse and/or child who elects continuation coverage under these conditions may not add any additional newly eligible dependents during special or open enrollment periods.