Commonwealth of Virginia Health Benefits Program
Extended Coverage/COBRA Change Request

This form should be used by qualified beneficiaries to make allowable changes to an existing Extended Coverage/COBRA plan or membership.

For initial COBRA enrollment, submit the Election Form provided in your Election Notice. Your Election Notice also includes information about your Extended Coverage/COBRA rights and responsibilities.

PART A: Identification of the Qualified Beneficiary/Enrollee Submitting the Form

PLEASE PRINT

Name _____ Health Plan ID Number _____
First Name M.I. Last Name

Address _____
Street City State Zip + 4

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex: ☐ Male ☐ Female Date of Birth _____
MM/DD/YYYY

PART B: Requesting Changes to Membership Level

After initial enrollment, you may make changes to your plan and membership during the annual Open Enrollment (non-Medicare coordinating plans only) or within 60 days of a qualifying mid-year event. The change must be consistent with the event. These are the same opportunities available to similarly-situated non-Extended Coverage/COBRA participants. COBRA qualified beneficiaries may end coverage at any time by stopping premium payment.

Ending Coverage

Since each qualified beneficiary has an independent right to coverage, individuals may end Extended Coverage/COBRA at any time by ceasing to pay his/her monthly premium (or his/her part of the total premium) by the end of the payment grace period. If you wish to end coverage for individual members of your family group, please notify the plan by submitting the following information:

☐ Premium payment will be stopped for the following qualified beneficiary/ies

Name/s of affected qualified beneficiary/ies: _____

If you wish to end coverage for all qualified beneficiaries and dependents in your covered family group, stop paying the total premium. Coverage will be terminated at the end of the payment grace period.

If coverage is to end for the following reasons, please check the appropriate box, and provide documentation to support the change (this could affect the date of change). Some changes (*) may require termination of Extended Coverage/COBRA. See your Election Notice for more information.

Name/s of affected qualified beneficiary/ies or dependent/s: _____

☐ Death of qualified beneficiary/dependent
☐ Qualified beneficiary/dependent gained entitlement to Medicaid
☐ Judgment, decree or order issued to end a child's coverage
☐ Qualified beneficiary enrolled in other group health plan coverage*
☐ Qualified beneficiary became entitled to Medicare (A, B or both)*
☐ Qualified beneficiary has ceased to be disabled during the disability extension as determined by the Social Security Administration*

Membership Increases

If you are requesting an increase in membership, please indicate the qualifying event below and attach documentation to support the event.

Name/s of dependent/s to be added: _____

☐ Marriage**
☐ Birth or adoption**
☐ Judgment, decree or order issued to add a child
☐ Spouse or child lost government-sponsored plan, Medicare or Medicaid
☐ Spouse or eligible child lost employer eligibility
☐ Qualified beneficiary gained permanent sole custody of a child
☐ Open Enrollment (plan and/or membership change)
☐ Other HIPAA Special Enrollment**
__ Dependent loses coverage for which they declined enrollment in this plan
__ Dependent loses coverage in Medicaid or the State Children's Health Insurance Program (CHIP)
__ Dependent becomes eligible for Medicaid or CHIP premium assistance subsidy
☐ Other: _____

**HIPAA Special Enrollments allow the addition of all eligible dependents

Second Qualifying Event

The following second qualifying events can result in increased duration of the Extended Coverage/COBRA period. See your Election Notice for additional information and requirements. You must provide documentation to support these events.

Name/s of affected qualified beneficiary/ies: _____

☐ Covered child ceased to be eligible under provisions of plan
☐ Divorce from former employee
☐ Determined to be disabled by the Social Security Administration
☐ Death of former employee

PART C: Requesting Changes To Plan

Indicate plan in which qualified beneficiary/ies are requesting enrollment (based on reason indicated in Part B).

STATEWIDE HEALTH PLANS

- ☐ COVA Care (with preventive dental) (ACC0)
- ☐ COVA Care + Out of Network (ACC1)
- ☐ COVA Care + Expanded Dental (ACC2)
- ☐ COVA Care + Out of Network and Expanded Dental (ACC3)
- ☐ COVA Care + Expanded Dental + Vision & Hearing (ACC4)
- ☐ COVA Care + Out of Network + Expanded Dental + Vision & Hearing (ACC5)
- ☐ COVA HealthAware (with preventive dental) (CHA)
- ☐ COVA HealthAware + Expanded Dental (CHA2)
- ☐ COVA HealthAware + Expanded Dental & Vision (CHA1)
- ☐ COVA HDHP - High Deductible Plan (with preventive dental) (CHD)
- ☐ COVA HDHP - High Deductible Plan + Expanded Dental (CHD1)

REGIONAL HEALTH PLAN

- ☐ Kaiser Permanente HMO- available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP)
- ☐ Optima Health HMO - available primarily in Hampton Roads zip codes (OHP)
- ☐ Other _____

FAMILY MEMBERS TO BE COVERED (list all to be covered, not just additions)

NAME PLEASE PRINT (include last name if different)	BIRTHDATE MM/DD/YYYY	SOCIAL SECURITY NUMBER
Former Employee		
Spouse		
Children		

If you need more space, attach a separate sheet of paper to this form.

PART D: Certification

ENROLLEE STATEMENT: I want to make a change in Extended Coverage/COBRA enrollment. I understand that I will be billed directly for the monthly premium. Once enrolled, I understand that changes may only be made at Open Enrollment or with certain qualifying midyear events (see Part B) when the changes are consistent with the events. I have read and understand my rights and responsibilities as explained in my Election Notice. I understand that my premiums are subject to change and that the Commonwealth of Virginia reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability just as those requirements apply to similarly-situated Non-Extended Coverage/COBRA health plan participants. I understand that non-payment of premium will result in cancellation of coverage per the provisions of the Public Health Service Act as described in my Election Notice and that claims will not be processed during the defined grace period until premium is paid.

CERTIFICATION/AUTHORIZATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name_____ Social Security Number_____

Sign Here_____ Date _____

Return this form to: Office of Health Benefits Extended Coverage/COBRA Administrator
101 North 14th Street, 13th Floor
Richmond, VA 23219

FOR OHB COBRA ADMINISTRATOR USE

- ☐ Change processed/effective date _____
- ☐ Change denied

OHB Staff Member _____ Date _____