COBRA COVERAGE APPLICATION

_____	_____
Name of Employee	SSN of Employee
_____	_____
Street Address	County or Subgroup
_____	_____
City, State Zip Code	Last Effective Date of Employee=s Group Coverage
_____	
Phone	

Plan Administrator: Nebraska County Insurance Trust

A. By Public Law 99-272, employees subject to termination (or a reduction in hours of employment) are entitled to continue insurance coverage with Blue Cross Blue Shield of Nebraska until the earliest of the following:

(1) Eighteen months from the date shown above.

(2) The date you become eligible for other group hospital, surgical, or medical coverage, whether insured or self-insured, or you become entitled to Medicare.

(3) The date of expiration of the monthly period for which premiums were paid in the event of nonpayment of premium.

(4) The date you exercise your privilege provided under our Blue Cross and Blue Shield contract for conversion to an individual or family contract of your own.

(5) The date of termination of the group contract with Blue Cross and Blue Shield of Nebraska.

B. The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days of receiving the determination from the Social Security Administration and before the end of the original 18-month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

In order to elect to continue coverage, sign one copy of this form and mail it to:

Nebraska Association of County Officials
1335 H St
Lincoln, Nebraska 68508

This election form must be completed and returned within 60 days after receiving this notice. The first premium must be paid within 45 days after you decide to continue your insurance coverage. Thereafter, premium payments are generally due within 30 days after the first day of each month of coverage. Premium amounts change from time to time. You will be notified of any change in the premium amount. If you fail to timely pay the initial premium or any subsequent monthly premium, your coverage will terminate.

ELECTION TO CONTINUE COVERAGE

I, the undersigned, **DO** elect to continue my insurance coverage with Nebraska County Insurance Trust through Blue Cross and Blue Shield of Nebraska in accordance with the provisions of the above notice. I understand that I am required to pay my insurance premiums without further notice. I also acknowledge with the following signature that I have reviewed **all** materials included with this application packet.

_____ _____
Signature Date

Please make a photocopy of this application to keep for your records.

I, the undersigned, **DO NOT** elect to continue my insurance coverage with Nebraska County Insurance Trust through Blue Cross Blue Shield in accordance with the provisions of this notice.

_____
Signature

_____
Date

_____
Social Security Number

Please make a photocopy of this application to keep for your records.