

Name: _____ SSN or Insurance ID: _____
 Last First MI

Mailing Address: _____
 Street City State Zip Code

Date of Birth: ____/____/____ Phone: _____ Email: _____

1) I am: a former employee a participating family member

If you are a participating family member, please list current or former employee information:

Name: _____ Emp. Soc. Sec. No. _____ - _____ - _____

2) I DO elect continuation coverage.

You must also complete the Direct Payment Plan form and attach a voided check with your application.

I DO NOT elect continuation coverage. (Please complete the information above, sign and return this form.)

3) Participant and/or dependent information for each person who will be continuing coverage:

Name	Birth Date	Soc. Sec. No.	Which Plan(s)?

4) I request continuation coverage for the following plans: (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Health Plan | <input type="checkbox"/> Medical Flexible Spending Account |
| <input type="checkbox"/> Low Deductible Health Plan (\$1,500) | <input type="checkbox"/> Dental Plan |
| <input type="checkbox"/> High Deductible Health Plan (\$2,200 \$4,400) | <input type="checkbox"/> Base Plan |
| | <input type="checkbox"/> Enhanced Plan |
| | <input type="checkbox"/> Vision Plan |

5) Non-tobacco User or Tobacco User?

- | | |
|---|---|
| <input type="checkbox"/> I am not a tobacco user | <input type="checkbox"/> My covered spouse is not a tobacco user |
| <input type="checkbox"/> I am a tobacco user | <input type="checkbox"/> My covered spouse is a tobacco user |

6) Which qualifying event(s) make you eligible for continuation coverage?

- | | |
|---|--|
| <input type="checkbox"/> Employee Termination | <input type="checkbox"/> Divorce or Legal Separation |
| <input type="checkbox"/> Employee Death | <input type="checkbox"/> Receiving Coverage Under Medicare |
| <input type="checkbox"/> Reduction of Employee's Hours | <input type="checkbox"/> Disabled Employee |
| <input type="checkbox"/> Child is Ineligible to be Covered as a Dependent | <input type="checkbox"/> Retired Employee* |
- * Watch for Retiree Enrollment forms coming soon.

I represent that the foregoing information is, to the best of my knowledge and belief, accurate. I agree that to retain coverage, I (we) must abide by the Plan's provisions.

Applicant Signature
 BHR Form COBRA

Date Signed

SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN

FY20 PLAN YEAR

July 1, 2019 – June 30, 2020.

COBRA Monthly Contribution Rates

Starting July 1, 2019, the following monthly premium rates will apply for pre-65 Retiree Health Plan members:		
	Low Deductible Plan (\$1,500)	High Deductible Plan (\$2,200/\$4,400)
Participant Only	\$634.89	\$595.10
Participant + Spouse	\$1,371.19	\$1,284.82
Participant + Child(ren)	\$975.39	\$916.19
Participant + Family	\$1,711.04	\$1,605.24

NOTE: Contributions for retiree and spouse coverage will increase \$60.00 per person per month if retiree and/or covered spouse use tobacco.

DENTAL		
	Base Dental Plan Premiums	Enhanced Dental Plan Premiums
Participant Only	\$33.05	\$53.39
Participant + Spouse	\$65.99	\$106.59
Participant + Child(ren)	\$72.24	\$108.69
Participant + Family	\$105.18	\$161.91

VISION	
Coverage Level	Monthly Premiums
Participant Only	\$7.22
Participant + Spouse	\$14.46
Participant + Child(ren)	\$12.24
Participant + Family	\$20.20