BlueCross BlueShield Nebraska

Extension of Coverage Request for Extended Eligibility to Age 30
Group Plans

Nebraska law allows a dependent who ceases to be a full-time student or attains an age exceeding the specified age at which coverage ceases pursuant to the plan, to continue coverage through the end of the month in which the dependent: (a) marries; (b) ceases to be a resident of the state, unless the child is under 19 years of age or is enrolled on a full-time basis in any college, university or trade school; (c) receives coverage under another health benefit plan or self-funded employee benefit plan; or (d) attains 30 years of age. The subscriber will be billed an additional premium for such coverage equivalent to that of a single adult.

This form must be completed and returned to Blue Cross and Blue Shield of Nebraska no later than 31 days after the date in which the dependent would otherwise lose coverage under the plan.

SECTION I

Name of Subscriber: _____

Address of Subscriber: _____

Identification Number: _____

Name of Dependent: _____

Dependent's Date of Birth (Mo., Day, Year): _____

Address of Dependent: _____

Is the dependent named above married: Yes ☐ No ☐

If yes, provide the date of marriage: _____

Is the dependent named above a resident of Nebraska: Yes ☐ No ☐

If no, provide the date the dependent moved from Nebraska : _____

Does the dependent named above have other health insurance coverage: Yes ☐ No ☐

If yes, provide the date coverage was effective: _____

SECTION II Acknowledgment & Signature

I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on this enrollment form may cause the coverage to be void. I further understand that Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I understand that my premium will be increased in an amount equivalent to a single adult premium, and that I must pay my employer for this coverage. I authorize my employer to deduct from my earnings any required premiums.

Signature of Subscriber: _____

Date: _____

PLEASE NOTIFY YOUR EMPLOYER REGARDING YOUR INTENTION TO MAINTAIN COVERAGE FOR YOUR DEPENDENT