STATE CONTINUATION COVERAGE ELECTION

Samaritan Health Plans

Read the important information about your rights in the notice included with the election form. **If you do not submit a completed election form by the due date below, you will lose your right to elect state continuation coverage.**

Please note: You may only elect to continue the same medical coverage you had before your qualifying event.

Please follow these election procedures:

1) Complete, sign and date this *State Continuation Coverage Election* form and make a copy for your records.
2) Mail this election form to: Samaritan Health Plans, PO Box M, Corvallis, OR 97339 *or* hand-deliver to: 2300 NW Walnut Blvd, Corvallis, OR 97330.
3) This election form must be date stamped or post-marked **within 10 calendar days** from the date on the *State Continuation Coverage Election Notice* or the qualifying event date, whichever is later. **No late elections will be accepted.**
4) Call Samaritan Health Plans at 1-800-832-4580 within 5 business days to ensure the election form has been received.

SUBSCRIBER INFORMATION & ELECTION		
Last name:	First name:	Middle initial:
Social Security Number:	Date of birth (mm/dd/yyyy):	
Address:		Phone:
Gender: ❑ Male ❑ Female	Marital Status: ❑ Single ❑Married ❑ Divorced/Separated ❑Widowed ❑Domestic Partnership	
Subscriber election: ❑ None ❑ Medical – *If you have **not** been covered by a Samaritan plan for the last three consecutive months, please provide:* Name of most recent insurance company: Member ID#:		

DEPENDENT(S) INFORMATION & ELECTION						
Last name	First name	Date of birth	Social Security Number	Gender	Relationship to subscriber	Election
						❑ Medical
						❑ Medical
						❑ Medical
						❑ Medical
						❑ Medical

OTHER COVERAGE AND MEDICARE ELIGIBILITY		
Are any applicants for state continuation coverage currently covered or plan to be covered by other group insurance or Medicare in the next nine months? ❑ No ❑ Yes *If yes, please complete the following for each of those applicants:*		
Full Name of Member:	Name of Other Carrier: ❑ Now: ID No. _____ ❑ Future Date: / /	Eligible for Medicare: ❑ Now: ID No. _____ ❑ Future Date: / /
Full Name of Member:	Name of Other Carrier: ❑ Now: ID No. _____	Eligible for Medicare: ❑ Now: ID No. _____

	❑ Future Date: / /	❑ Future Date: / /
Full Name of Member:	Name of Other Carrier: ❑ Now: ID No. ____________ ❑ Future Date: / /	Eligible for Medicare: ❑ Now: ID No. ____________ ❑ Future Date: / /
Full Name of Member:	Name of Other Carrier: ❑ Now: ID No. ____________ ❑ Future Date: / /	Eligible for Medicare: ❑ Now: ID No. ____________ ❑ Future Date: / /
Full Name of Member:	Name of Other Carrier: ❑ Now: ID No. ____________ ❑ Future Date: / /	Eligible for Medicare: ❑ Now: ID No. ____________ ❑ Future Date: / /
Full Name of Member:	Name of Other Carrier: ❑ Now: ID No. ____________ ❑ Future Date: / /	Eligible for Medicare: ❑ Now: ID No. ____________ ❑ Future Date: / /

STATEMENT AND SIGNATURE

I (We) elect state continuation coverage with Samaritan Health Plans and confirm I (we) meet the eligibility requirements described in the information provided.

Signature:	Date (mm/dd/yyyy):
Print name:	Relationship to subscriber and dependent(s):
Address:	Phone:

FOR SAMARITAN USE ONLY

State Continuation coverage:
❑ Standard Bronze ❑ Standard Silver ❑ Health & Wellbeing 5000/60 ❑ Health & Wellbeing 2500/20
❑ Health & Wellbeing 3000/20 ❑ New Performance PPO

Verified:
❑ Sub only ❑ Sub & Spouse ❑ Sub & Dep ❑ Family ❑ Dep only ❑ Spouse only ❑ Spouse & Dep

Continuation coverage effective date: ____/____/____ Continuation coverage termination date: ____/____/____
New Sub ID needed: ❑ Yes

Notes: