BlueCross BlueShield of Illinois

ILLINOIS STATE CONTINUATION GROUP REQUEST FORM ONLY

(For COBRA requests, go to http://bcbsil.com/employer/newsupdate/cobra.htm or contact your group administrator)

Date: _____

Group number: _____ Subscriber number: _____

Employer name: _____

Group Contact Name: _____ Phone number: _____

Email copy of notification letter to Group: ☐ **YES** ☐ **NO** Contact Email Address: _____

BCBSIL Membership Services (FSU):

Please be advised of a member's request concerning the right to continue health insurance per the Illinois Continuation Privilege or mandate. Please forward required notice and election forms.

QUALIFYING EVENT: _____

EVENT EFFECTIVE DATE: _____

NAME OF PERSON TO BE NOTIFIED (please print): _____

SOCIAL SECURITY NUMBER (required): _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TYPE OF CONTINUATION NOTICE (select one)					
☐ Spousal	☐ Dependent Child	☐ Deputy	☐ Police Officer	☐ Fireman	☐ Municipal Employee

COVERAGE TIER			
☐ Self	☐ Self + Spouse	☐ Self + Children	☐ Self + Family

LIST ANY ADDITIONAL DEPENDENTS TO BE INSURED		
Name	**Relationship**	**Date of Birth (MM/DD/YYYY)**

Please return the completed request form by using one of the suggested methods as noted below. *For confirmation of faxed and mailed requests, please contact your FSU**		
Email (*preferred method*)	**Fax***	**U.S. Mail***
ILStateContinuation@bcbsil.com	*1-618-998-2747*	*Illinois Continuation Service Unit* *PO Box 655082* *Dallas, TX 75265-5082*

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