



Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

**FLEXIBLE BENEFITS PLAN
MEDICAL REIMBURSEMENT ACCOUNTS
CONTINUATION ELECTION FORM**

(Page 1 to be completed by employer, Page 2 by qualified beneficiary)

TO: _____ **DATE:** ____/____/____
(Including your spouse and dependents, if any)

FROM: _____

QUALIFYING EVENT: _____

DATE OF QUALIFYING EVENT: ____/____/____

Unless you elect COBRA Continuation Coverage, your contributions to the Medical Reimbursement Account under the Flexible Benefits Plan will terminate as of the Date of the Qualifying Event. Your contributions to the Medical Reimbursement Account would normally terminate as of _____ (end of current plan year). Benefits under the Medical Reimbursement Account are described in the Summary Plan Description of the Flexible Benefits Plan. A copy of the Summary Plan Description is available from the Employer or from Wellmark Blue Cross and Blue Shield.

ELIGIBILITY

Individuals will be eligible for COBRA Continuation Coverage only if they have a positive Medical Reimbursement Account balance at the time of a Qualifying Event (taking into account all claims submitted before the date of the qualifying event). If you have a positive Medical Reimbursement Account balance and you decide not to purchase continuation coverage, you will forfeit the value of the positive balance. Please consider your decision carefully. Since you will be required to pay the cost of the continuation coverage with after-tax dollars, you may conclude there is no advantage to purchasing continuation coverage under the Medical Reimbursement Account.

CONTINUATION PERIOD

If COBRA Continuation Coverage is elected, it will commence on the date of the Qualifying Event and will be available only for the remainder of the plan year in which the qualifying event occurs.

ELECTION AND PREMIUM PAYMENT

Each qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage. A covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event, and a parent or legal guardian may elect continuation coverage on behalf of a minor child.

If you decide to continue coverage, please indicate on this form and return it to the address shown within 60 days after the later of: (a) the date coverage would otherwise end, or (b) the date of this notice. It will then be your responsibility to continue to send a monthly premium check or money order made payable to Wellmark Blue Cross and Blue Shield.

Monthly Premium Amount \$ _____ (Monthly Contribution + 2%)

REVOKING AN ELECTION

If you elect not to continue coverage, you may revoke that election and elect to continue coverage as long as the election to continue is made by the date stated above under ELECTION AND PREMIUM PAYMENT. You may obtain a new election form from Wellmark Blue Cross and Blue Shield by contacting the address or phone number at the bottom of page 2.

PLEASE NOTE: This election form does not fully describe continuation coverage or other rights under the flexible benefits plan. More complete information regarding such rights is available in the plan's summary plan description or from the plan administrator.

**FLEXIBLE BENEFITS PLAN
MEDICAL REIMBURSEMENT ACCOUNTS
CONTINUATION ELECTION FORM**
(To be completed by the qualified person making election)

I wish to continue coverage under my Medical Reimbursement Account:

Yes No

Signature of Qualified Person

____/____/____
Date

Name of Employer

Social Security Number

If you elect to continue coverage, it is suggested that you submit with this form the full premium for the period from the date coverage would otherwise end through the current month. However:

1. If your election is made more than one month after the date coverage would otherwise end, you may defer premium payment for the monthly premium period(s) preceding the election. Such deferred payment period: (a) cannot exceed the 45-day period immediately following the date you sign this election form; and (b) applies only to the monthly premium period(s) preceding the month in which your election is made.
2. Payment of premium for the month in which your election is made may also be deferred-however, this deferred payment period cannot exceed the 30-day period immediately following the date you sign this election form.
3. Premium for any subsequent month of continuation coverage must be paid not later than 30 days after the first day of such month.
4. In the event of a failure to pay any premium by the time it is due, or by the end of any applicable grace period, the plan will cease reimbursements for any claims incurred on or after the actual date of the premium, without any grace period.

Please sign, date, and return this form to:

Flexible Benefits Department
Wellmark Blue Cross and Blue Shield
PO Box 14585
Des Moines, Iowa 50306-3585

Telephone Number: 800-624-2755

This form must be postmarked by the deadline for making an election (later of 60 days following the date coverage would otherwise end or 60 days following the date of this notice).