BUILDING INDUSTRY INSURANCE TRUST (BIIT)

Continuation Coverage Election Form

A. Employee / Employer Information:

Employee Name:_____
(Please print - last name, first name, middle initial)

Employee Date of Birth:_____

Employee Social Security #: _____

(Former) Employer: _____

Employer Group #: _____

Is disabled and/or over age 65 employee or former employee "entitled" to Medicare benefits? Yes No
If "Yes", indicate date of Medicare Entitlement: _____

B. Qualifying Event / Type of Coverage:

1. Indicate which QUALIFYING EVENT caused applicant's Loss of Coverage:
   a. ☐ Termination of employment/reduction in hours
   b. ☐ Death of Employee (☐ 55+ Surviving Spouse)
   c. ☐ Divorce (☐ 55+ Former Spouse)
   d. ☐ Dependent Child no longer eligible
   e. ☐ Other (explain) _____
2. Date of Qualifying Event: _____
3. Last date of coverage _____

4. Indicate type of Continuation Coverage requested: Continue coverage for (check only one box):
   a. ☐ Employee Only
   b. ☐ Dependent(s) Only
   c. ☐ Employee & Dependents

Plan Selections:
☐ MEDICAL ☐ DENTAL ☐ VISION
(You can only elect plans that you were enrolled in through your former employer)

Note: Life and AD&D insurance coverages are not included

C. Applicant Information: (Applicant is Employee unless Dependent Only Continuation Coverage is elected)

1. Applicant's Name:_____
(Please print - last name, first name, middle initial)

2. Social Security #: _____

3. Address: _____

_____
(City) (State) (Zip)
(Monthly billing statement and all correspondence will be sent to this address)

4. Applicant's Birthdate: _____

5. Telephone #: _____

6. Email: _____

7. List all Dependents for whom Continuation Coverage is elected: (continue on additional page if necessary)

Name of Dependent	Social Security #	Date of Birth	Relationship to Employee

D. Terms and Conditions: Note: application will not be processed until payment is received

I elect Continuation Coverage on the applicant and dependents (if any) listed above in accordance with the Continuation Coverage terms and conditions listed on the back of this form. I agree to make retroactive rate payment within 45 days of the date of this election for all months outstanding since my employer sponsored coverage ended. I agree to make future rate payments in full within the time frames specified on the back of this form. I haveread, understand and agree to the Continuation Coverage provisions set forth on the back of this form:

Applicant's Signature:_____ Date: _____

Checks must be made payable to the appropriate Trust.
Return this Form and Payment To:
15375 SE 30th PL. #380
Bellevue, WA 98007

Administrator's Use Only
COBRA No:_____ Cov. _____
Effective Date: _____

BUILDING INDUSTRY INSURANCE TRUST (BIIT)
Continuation Coverage
Terms and Conditions for Participation

1. You are eligible for Continuation Coverage only if (1) the Employer is a current participant in the BIIT program and (2) the Employer has certified it is subject to the Continuation Coverage law.

2. To elect Continuation Coverage, you must complete and submit this Continuation Coverage Election Form to the Trust Administrator within 60 days after the day coverage terminated, or, if later the day your Employer gave you this Continuation Coverage Election Form (provided the Employer met their 44 day Continuation Coverage notification requirement). If the Employer does not meet the 44 day notification requirement described above, this Election Form must be received, or postmarked, within 104 days from the later of the Continuation Coverage qualifying event or the date coverage under the plan terminates. If your Election Form is not received within the 104 day period Continuation Coverage will not be provided through the BIIT program.

3. You must submit your first Continuation Coverage rate payment within 45 days after the date you elect Continuation Coverage on the Election Form. Your first retroactive rate payment must be for the full amount necessary to cover the initial rate months. The "initial rate months" are the months that end on or before the 45th day after the date of the Continuation Coverage election. After the first rate payment, rate payments are due on the first day of each month for that month's Continuation Coverage, and must be paid in full within 30 days after the first day of the month. If you fail to make full payment within the required time periods, Continuation Coverage terminates retroactively to the last day of the month for which full timely payment has been made, and will NOT be reinstated.

4. The rate for Continuation Coverage is 102% of the rate charged to similarly situated individuals covered under the Former Employer's group plan. Rates are subject to change at least annually. Rates are also subject to change in the event of a benefit change elected by the Former Employer. Continuation Coverage participants are eligible only for the same BIIT Medical, Dental and Vision benefits selected by the Former Employer.

5. If the employee's spouse, Oregon-registered domestic partner or dependent child loses plan coverage because of the employee's death, divorce, or termination of Oregon-registered domestic partnership, the dependent child loses plan coverage because he or she ceases to be a dependent under the plan, the maximum coverage period (for spouse, Oregon-registered domestic partner and dependent child) is 3 years* from the first day of the month following the qualifying event. (*If the surviving spouse, former spouse or Oregon-registered domestic partner is age 55 or older, the 3 year maximum coverage period does not apply. Continuation coverage may be maintained until the earliest of the date the surviving spouse, former spouse or Oregon-registered domestic partner becomes covered by another group health plan, becomes eligible for Medicare, remarries, or the date the employer no longer provides group coverage.) If the employee, spouse, domestic partner or dependent child involuntarily loses plan coverage because of a termination or reduction in hours of the employee's employment, the maximum continuation coverage period (for the employee, spouse or dependent child) is 18 months from the first day of the month following the termination or reduction in hours of employment. There are two exceptions:

- If an employee or family member is disabled at any time during the first 60 days after the termination or reduction in hours of employment, the maximum coverage period for the disabled individual and the family members who elect Continuation Coverage is 29 months from the first day of the month following termination or reduction in hours. The disability that extends the 18 month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the BIIT Administrator within the 18-month coverage period and within 60 days after the date of the determination.

- If a second qualifying event that gives rise to a 36 month maximum coverage period occurs (for example, the employee dies, divorces, termination of Oregon-registered domestic partnership or a child ceases to be an eligible dependent) within the 18-month or 29-month coverage period, the maximum coverage period for the spouse, Oregon-registered domestic partner and dependent child becomes 3 years from the first day of the month following termination or reduction in hours of employment.

6. Continuation Coverage terminates (even before the end of the maximum coverage period) when any one of the following events occur:

- You request early termination. A written request must be received before or during the month of the requested termination date.
- The Former Employer no longer provides a medical, dental or vision plan through the BIIT (as the case may be) to any of its employees;
- The full rate payment for Continuation Coverage is not timely paid.
- You (employee, spouse, domestic partner or dependent child) become covered under another group health plan .
- You (employee, spouse, domestic partner or dependent child) become entitled to Medicare benefits (applies only to person entitled to Medicare).
- If you became entitled to a 29-month maximum coverage period, but then there is a final determination under Title II or Title XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled. However, Continuation Coverage will not end until the month that begins more than 30 days after the determination.
- An event occurs that permits termination of coverage under the BIIT for cause.
- The surviving spouse, former spouse or Oregon-registered domestic partner is age 55 or older remarries.

7. Your application cannot be processed until we receive your initial premium payment. In addition, all claims including prescription drug benefits, occurring after your loss of coverage will be held in pending status. Once full payment has been received, and your former employer has paid their monthly premium, all eligible claims will be released for payment according to the terms of the health insurance contract.