Department of Defense Nonappropriated Fund Health Benefits Program (DOD NAF HBP) Group Health Benefits Temporary Continuation of Coverage (TCC) Application

Employer section (Each NAF division must complete this section to ensure proper processing. If it's incomplete, we'll deny the form.)

1. To: Eligible applicant's name				
2. From: Employer			3. Control number	4. Inspira employer number
5. Address				
6. City			7. State	8. ZIP
9. Suffix	Account	Plan	10. Date applicant's group insurance ends	11. TCC end date
Employer's authorized signature *(Human Resources Office)*				

You can get temporary continuation of group health coverage if you meet any of these conditions:

☐ 1. The employee's employment has ended (includes retirement or layoff) or loss of eligibility due to reduction in hours on _____.
☐ 2. The employee's death on _____.
☐ 3. The employee's divorce or legal separation effective _____ .
☐ 4. A dependent child has ceased to be an eligible dependent (has reached limiting eligibility age under the group health policy) as of _____.
☐ 5. Loss of employment due to disability.

Note: You are not eligible for TCC coverage if employee loses coverage due to employment termed due to cause, enrollment in TRICARE-for-Life, or becomes eligible for Medicare.

Your group health coverage will end because of the reason and on the date cited above unless you comply with these requirements:

Before _____ (which is 60 days after the date coverage ends), you must complete the Direct Billing Enrollment Request below to continue coverage. Return it to the address on the back of this form along with your check for the first payment.

The check for the first payment must cover the number of full months from the insurance end date above, to the date you elect continuation coverage.

Coverage available: Medical

The monthly cost for continued group health coverage is: Single $_____ Single + Child(ren) $_____ Single + Spouse $_____ Single + Family $ _____

NOTE: Rates are subject to audit by Aetna or Department of Defense. (Any adjustments in premium will be reflected on your next monthly statement.) After the first payment, you must submit the monthly payment you're billed until we've told you about a general change for all participants. If you don't pay the bill within 31 days of the due date, your coverage will end on that date. It can't be reinstated.

Make check payable to: Inspira Systems, USA, Inc.

Respond quickly. You'll be reinstated early. And you'll avoid claims delays.

Direct billing enrollment information — Must be completed

Applicant section (See other side for instructions on items 1-8 below and on where to mail.)

1. Applicant's name (last, first, middle initial)	2. Applicant's Social Security number	3. Employee's Social Security number (If applicant is other than former employee)
4. Applicant's birth date *(MM/DD/YYYY)*	5. Applicant's address (street, city, state, ZIP code)	6. Telephone number

7. Coverage is for:

☐ **Single**
- ☐ Self only
- ☐ Spouse only
- ☐ Child only
- ☐ FSA & amount

☐ **Family**
- ☐ Self & spouse
- ☐ Self & child/children
- ☐ Spouse & child/children
- ☐ Self, spouse & child/children

If you or any of your dependents are covered under another group health plan, please indicate type of coverage, health plan sponsor and family members covered.

_____

_____

_____

8.	Name (First, middle initial, last)	Social Security number	Rel. Code*	Gender	Birth date MM / DD /YYYY
Employee			**Self**		/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /
Dependent					/ /

** Relationship Codes: Husband (H); Wife (W); Son (S); Daughter (D); Sponsored son (Y); Sponsored daughter (X)*

A check to cover the number of months from the date group insurance ends should accompany this enrollment.

Applicant's signature (required)	Date

If you make the monthly payment(s) as indicated, your group health coverage will be continued for up to:

- 18 months following end of employee's employment or lost eligibility due to reduction in hours.
- 18 months following the date of the employee's divorce, legal separation, or dependent child's ineligibility.
- 36 months for eligible dependents following the death of an employee.
- 36 months following end of employment due to disability.
- The date on which the DOD NAF HBP ceases to provide any employee health coverage. (However, if health coverage is replaced, you'll get continuation of coverage under the terms of the new arrangement.)
- The date following your end date on which you are or become covered under another group health plan or enrolled in Medicare.

Instructions for completing the direct billing enrollment information

To be completed **by the former employee** if block 1 or 5 is checked; **by the spouse** if block 2 or 3 is checked; and **by the former dependent child** if block 4 is checked.

Item No. 1 Please enter your name: (last, first & middle initial).

Item No. 2 Enter your Social Security number.

Item No. 3 Enter the Social Security number of the employee who originally held the coverage under the group. This should be completed for all applicants other than the former employee.

Item No. 4 Your date of birth.

Item No. 5 Enter your full address.

Item No. 6 Include a telephone number where we can contact you.

Item No. 7 Check off either block to advise of any dependent coverage information. Enrollment coverages will be the same for all family members unless you complete a separate request form.

Item No. 8 List applicant's dependents eligible for coverage.

You should list the name, relationship, gender, and birth date of all eligible dependents. These dependents must have been covered under the group at the time of the qualifying event.

Sign and date the form. Keep a copy for your files and send the original, along with a check* for the coverage period to date, to:

Inspira Financial Health, Inc.
BENEFITS BILLING DEPARTMENT
PO BOX 953374
ST. LOUIS, MO 63195-3374

***Reminder: The check for the first payment must cover the number of full months from the insurance end date to the date you elect continuation coverage.**

Participant's responsibilities

- Send monthly premiums to the Direct Billing Unit by the due date.
- Submit claims as normal to the Claim Benefit Payment Office.
- Notify Direct Billing Unit of changes in dependent status (provide proof).
- Notify Direct Billing Unit of name and address changes.
- Report any other new group health coverage.