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COBRA CONTINUATION COVERAGE ELECTION NOTICE

[Enter date of notice]

Dear: [enter Name of Employee, Spouse, Dependent Children, as appropriate]

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan).

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address]. If you do not elect to continue your health care coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on [enter date] due to:

- End of employment
- Reduction in hours of employment
- Death of employee
- Divorce or legal separation
- Enrollment in Medicare
- Loss of dependent child status

Each of the following persons is entitled to elect to continue health care coverage under the Plan:

- Employee — [enter name]
- Spouse (or former spouse of employee) [enter name]
- Dependent children [enter name(s)]

Because of the event (checked above) that will end your coverage under the Plan, you [and/or, as appropriate, your spouse, and dependent children] are entitled to continue your health care coverage for up to _____ months [enter 18 or 36 months, as appropriate]. If you elect to continue your coverage under the Plan, your continuation coverage will begin on [enter date] and can last until [enter date]. Your continuation coverage will cost: [enter amount each qualified beneficiary would be required to pay for each option per month of coverage and any other permitted coverage periods.]

IMPORTANT - To elect continuation coverage you MUST complete the enclosed "Election Form" and return it to us. You may mail it to the address shown on the Election Form [or describe other acceptable means of submission]. The completed Election Form must be post-marked by [enter date] [or received by [enter date] if submitted by other means]. If you do not submit a completed Election Form by this date, you will lose your right to elect continuation coverage. Important information about your rights is provided to you on the pages after the Election Form.

COBRA CONTINUATION COVERAGE ELECTION FORM

[Name of Employee / Spouse / Dependent Children (as appropriate)]

IMPORTANT: This form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than [enter date]. Send completed form to: [Enter Name and Address]

I (We) elect to continue our coverage in the [enter name of plan] (the Plan) as indicated below: Name Date of Birth Relationship to Employee SSN (or other identifier)

- a. _____
- b. _____
- c. _____
- d. _____

Type of coverage elected (check only one):

- [enter description of option]
- [enter description of option]
- [enter description of option]

Signature Date

Print Name Relationship to individual(s) listed above

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, a covered employee’s spouse, and dependent children of the covered employee. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including *[add if applicable: open enrollment and] special enrollment rights*. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan’s summary plan description (SPD), which can be obtained from *[enter name, address and telephone number of appropriate party (Plan Administrator or other party)]*.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud). *[If the maximum period of coverage of this notice is 18 months, add the following three paragraphs:]*

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify *[enter name of COBRA administrator]* of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify *[enter name of COBRA administrator]* of that fact within 60 days of the SSA’s determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify *[enter name of COBRA administrator]* of that fact within 30 days of SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee’s enrolling in Medicare, or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. You must notify *[enter name of COBRA administrator]* within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one. ***[If employees might be eligible for trade adjustment assistance, the following information may be added:]*** The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated *[if Plan permits, add:]* unless you request that your continuation coverage begin only with the date of your Election Notice up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact *[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment. Your first payment for continuation coverage should be sent to: *[enter appropriate payment address]*

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. *[Enter additional information on other due dates for payments if Plan permits other periodic payment schedules.]* Under the Plan, these periodic payments for continuation coverage are due on the *[enter due day for each month of coverage]*. *[If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:].* If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan *[select one: will or will not]* send periodic notices of payments due for these coverage periods. Periodic payments for continuation coverage should be sent to: *[enter appropriate payment address]*

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days *[or enter longer period permitted by Plan]* to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. *[If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]* If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

[If Plan provides any election of other health coverage besides continuation coverage (such as alternative coverage in lieu of continuation coverage, individual conversion rights, etc.), enter description of all such coverages and explain how election of such other coverages would affect continuation coverage rights under the Plan. The following are two separate examples of such a description:]

Can you elect other health coverage besides continuation coverage?

Under the Plan, you have the right to elect alternative group health coverage for a period of six months at no cost to you instead of the continuation coverage described in this Notice. If you elect this six-month alternative coverage, you will lose all rights to the continuation coverage described in this Notice. You should also note that if you enroll in the alternative group health coverage you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact *[add appropriate contact information]* if you wish to elect alternative coverage.

--OR--

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from: *[enter name, address and telephone number of appropriate party (plan administrator or other party)]*. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.