

CHECK LIST/COBRA

When an Employee Terminates Employment or has number of hours reduced, making him/her ineligible for benefits; or when a dependent loses coverage due to death of the employee, because of employee/spouse electing Medicare as primary coverage, divorce, marriage, or because he/she is beyond the limiting age:

Within 14 Days of benefit termination notice, the employee (or dependent losing coverage) must be provided: (Note: Employers that administer their own plans have 44 days to notify beneficiaries.

_____ Right of Continuation Letter advising of continuation and/or conversion rights.

_____ Continuation of Coverage Application/Form

_____ Notice that the above two items were received. ***This item should be signed and returned to the Employer immediately upon receipt of the above items.***

_____ Remember to retrieve any identification and/or Rx cards issued to the employee and/or dependents.

Within 30 Days:

_____ Employer must notify Insurance Carrier of termination in the normal manner, advising that the employee and/or dependent is/are eligible for continuation.

Within 60 Days: (of benefit termination or notification of continuation right, whichever is later):

_____ The continuation of coverage form must be returned by the employee (or dependent losing coverage) indicating that continuation is requested, or that continuation is declined. (this form should be returned to the Employer).

Within 45 Days After Accepting The COBRA Election:

_____ First payment due by Qualified Beneficiary retroactive to when coverage ended.

WAIVER LETTER

DATE:

RE: ***Waiver of Right to Continue Benefits
Under Cobra Continuation***

I have received the notification of the right to continue certain covered benefits for me and my covered dependents if any.

At this time, the undersigned Qualified Beneficiary:

- Waives the right to purchase the continuation for ME
- Waives the right to purchase the continuation for my SPOUSE
- Waives the right to purchase the continuation for my covered DEPENDENT(S), if any.

OR

- Waives the right to purchase the continuation for my covered DEPENDENT(S), if any,
With the exception of the following dependent child(ren).

In waiving this coverage, I (we) acknowledge that at the end of the election period _____, my (our), decision will be final and irrevocable.

Sincerely,

Signature of Employee

Signature of Spouse

Return the completed form to:

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

***IMPORTANT—** This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:
2. Name of group health plan:
3. Name of participant:
4. Identification number of participant:
5. Name(s) of any dependent(s) to whom this certificate applies:
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

7. **For further information call:**
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ___ and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____ (or check if coverage is continuing as of the date of this certificate: _____)

Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary

RIGHTS OF CONTINUATION LETTER

Date _____

Name _____
Address _____
City, State Zip _____

The health care coverage provided by _____ to you and to any of your dependents ends on _____.

(For spouse or dependent events only: the date when you were legally separated or divorced, or were no longer a qualified dependent as required under your benefit plan, or lose coverage under the _____ because your spouse or parent died or became covered under Medicare.) However, as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may elect to continue the medical, dental or vision plan coverage in which you and your dependents currently are enrolled and pay the applicable monthly premiums.

If you elect to extend your coverage, the benefits may continue for **18, 29** or **36** months (depending on qualified beneficiary status) but may end sooner when one of the following events occurs:

- A. You, or a covered dependent, become covered under any group health plan and that plan's preexisting medical conditions exclusions or limitations do not apply or are satisfied by you, or a covered dependent.**
- B. You, or your dependent becomes entitled to (covered by) Medicare benefits.**
- C. You fail to pay on time the monthly charge for this coverage.**
- D. _____ no longer sponsors any employee health plan.**
- E. The end of the period of Continuance to which you or your dependent is entitled.**

The monthly charge for continuation coverage is as follows: Medical _____ Dental _____ Vision _____

Individual coverage:

Individual and Spouse coverage:

Individual and Children coverage:

Family coverage:

Your first payment must be received no later than 45 days from the date when you return the attached election form for processing. Subsequently, you must submit you monthly premium in full by the first day of each month, but no later than 30 days after the due date.

If your first payment, or any subsequent payment, is not received timely, you will lose your option to continue coverage. Payments must be for the full amount of the required premium. Coverage is provided only when the full premium for the applicable period is received.

If you wish to continue coverage, please complete the attached election form. If you **do not wish** to continue coverage for yourself, your covered spouse and/or children **may elect** to continue their coverage on their own.

Should you have any question concerning this matter, please do not hesitate to contact this office.

Sincerely,

RECEIPT OF TERMINATION MATERIALS

For employee or Dependent who no longer meets the eligibility requirements of the group insurance contract.

NAME:

SOCIAL SECURITY NUMBER:

ADDRESS:

EMPLOYER:

INSURANCE CARRIER:

COVERAGE TERMINATION DATE:

I hereby certify that I have received the following materials relative to continuation of my group insurance coverage:

- Rights of Continuation Letter
- Continuation of Coverage Application

Signature

Date

You may, within the next 60 days, request a continuation of your group insurance coverage by submitting the completed "Continuation of Coverage" form to the Employer.

As explained on the attached letter, the premium for this coverage is the actual premium shown plus 2% (to offset additional administrative costs).

After you elect Continuation; submit the requested form (within 60 days); and remit premium (within 45 days of election), coverage will be made retroactive to your termination date.

If you are a terminated employee or are losing coverage due to a reduction of work hours, you may continue coverage as explained above for up to 18 months or in the case of total disability up to 29 months. If you are a dependent who is losing coverage due to divorce, marriage, death of the employee, etc., you may continue coverage for up to 36 months.

Please be sure to read the attached information for additional pertinent information.