

**COBRA NOTIFICATION**

Date: \_\_\_\_\_

Dear: \_\_\_\_\_

**This notice contains important information about your right to continue your health care coverage in the \_\_\_\_\_ Health 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 \_\_\_\_\_.

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 \_\_\_\_\_ 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 – \_\_\_\_\_
- Spouse - \_\_\_\_\_
- Dependent children \_\_\_\_\_

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. If you elect to continue your coverage under the Plan, your continuation coverage will begin on \_\_\_\_\_ and can last until \_\_\_\_\_. **In the event you were eligible for social security benefits at the time of the qualifying event, you may be able to extend your benefit until you are eligible for Medicare. You should advise us of your social security eligibility to determine if this extension of benefits is available to you under Connecticut law.**

Your continuation coverage will cost: \_\_\_\_\_

**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. The completed Election Form must be received by \_\_\_\_\_. 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: \_\_\_\_\_

**Important: This form must be completed and returned to our office.**

**Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I (We) elect to continue our coverage in the Benefit Plan as indicated below:

Name identifier)	Date of Birth	Relationship to Employee	SSN	(or	other
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a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

Type of coverage elected (check only one):

- Medical
- Dental
- Employee, Employee and Spouse, Children, Family
- Waive COBRA

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed  
above

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

## **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: open 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.

### **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, 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).

### **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 \_\_\_\_\_ 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 \_\_\_\_\_ 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 \_\_\_\_\_ of that fact within 30 days of SSA's determination.

## **Special Connecticut Extension**

**In the event the employee was eligible for social security benefits at the time of the qualifying event, you may be able to extend your benefit until you are eligible for Medicare. You should advise us of your social security eligibility to determine if this extension of benefits is available to you under Connecticut law**

## **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, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify \_\_\_\_\_ 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.

**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 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 \_\_\_\_\_ to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. Under the Plan, these periodic payments for continuation coverage are **due on the first day for each month of coverage**. 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 will not send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

\_\_\_\_\_

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days 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.**

### **For more information**

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 web site at [www.dol.gov/ebsa](http://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.