

**Initial Notice Form**  
**COBRA Notice Upon Enrollment in a Group Health Plan**

**VERY IMPORTANT NOTICE**

If a qualifying event occurs that causes you or your spouse or dependent children to lose coverage under \_\_\_\_\_ group health care plan, you have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of health coverage (herein called continuation coverage) at group rates. This notice is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. Both you and your spouse should take the time to read this Notice. Employees and other workers covered by \_\_\_\_\_ group health care plan can elect continuing coverage if one of the following qualifying events occurs:

- voluntary or involuntary termination of employment for reasons other than gross misconduct; or
- voluntary or involuntary reduction of work hours below the level required for participation in the group health plan.

The spouse of an employee or other individual covered by \_\_\_\_\_ group health care plan can elect continuing coverage if one of the following qualifying events occurs:

- the death of the employee or other covered individual;
- a termination of the employee's employment for reasons other than gross misconduct, or a reduction in the employee's hours of work below the level required for participation in the group health plan;
- a divorce or legal separation from the employee; or
- a retired employee's enrollment in Medicare.

The dependent child of an employee or other individual covered by \_\_\_\_\_ group health care plan can elect continuing coverage if one of the following qualifying events occurs:

- the death of the parent employee or other covered individual;
- the termination of employment or reduction of work hours of the parent employee;
- the divorce or legal separation of the parents, if this causes the dependent child to lose coverage under \_\_\_\_\_ group health plan;
- the enrollment in Medicare of the retired parent or employee; or
- the child's loss of dependent status due to attainment of the maximum age for coverage under the group health plan.

The employee or other covered individual or family member has the responsibility to inform \_\_\_\_\_ of a divorce, legal separation, or a child's loss of dependent status within 60 days of the qualifying event or the date on which group coverage would be lost because of the event. If you fail to provide the proper notice within 60 days, continuation coverage might not be available.

When a qualifying event occurs, you will receive notice within 14 days of your right to elect continuation coverage at that time. You will have 60 days to decide if you want continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end. If you choose continuation coverage, you will be offered coverage that is identical to the coverage provided to similarly situated active employees and family members. You will have the right to elect full coverage or medical coverage without dental insurance. If you had family coverage at the time of the qualifying event, you can elect family coverage or a less broad category of coverage.

Continuation coverage is available for up to 18 months if the qualifying event is the termination or reduction in work hours of the employee. If an employee or family member is disabled under the rules for Social Security disability benefits, the worker and family members are eligible for an additional 11 months of continuation coverage, for a total of 29 months. For other qualifying events, the spouse or dependent children are eligible for up to 36 months of continuation coverage. Furthermore, the 18-month period for termination or reduced work hours can be extended to 36 months for family members if a second qualifying event—for example, divorce, death, Medicare entitlement—occurs during the 18-month period. Continuation coverage also is available to covered retirees, their spouses, and widows or widowers of covered retirees if they should lose group health coverage as the result of \_\_\_\_\_ filing for bankruptcy. This coverage is available for the life of the retiree; widows and widowers and dependent children can continue coverage for 36 months after the death of the retiree.

Continuation coverage can be cut short of the full coverage period for any of the following reasons:

- \_\_\_\_\_ no longer provides group health coverage to any employees.
- The premium for continuation coverage is not paid in a timely fashion.
- You become covered under another group health plan that does not penalize or subject you to restricted or limited coverage due to a preexisting medical condition.
- You become entitled to Medicare.
- The disabled individual is no longer defined as disabled under Social Security rules during the 11 months of extended continuation coverage.

You do not have to show that you are insurable to choose continuation coverage. However, you have to pay for the coverage and are allowed a 30-day grace period for timely payments. At the end of your 18, 29, or 36 months of continuation coverage, you are allowed to enroll in an individual conversion health plan provided under \_\_\_\_\_ group health plan.

If you have any questions about your rights under COBRA, please contact the Human Resource Department. Please inform Human Resources of any change in marital status or change of address for you or your spouse.

**An Important Notice Concerning  
Your Employee Health Benefit Continuation Rights**

To: \_\_\_\_\_  
(Name of Qualified Beneficiary)

From: \_\_\_\_\_

RE: Health Insurance Continuation

Date of this Notice: \_\_\_\_\_

The federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires \_\_\_\_\_ sponsored group health plans to allow covered employees and their dependents to elect to continue their current coverage, at group rates, following a qualifying loss of coverage. Connecticut Public Act 97-268 requires all group health insurance plans to conform to the COBRA continuation-of-coverage periods. This notice is intended to inform employees and their eligible dependents of their rights and obligations under these laws.

**Under what circumstances may coverage be continued? (Qualifying Events)**

Your group health coverage would normally terminate on \_\_\_\_\_ due to the qualifying event listed below which occurred on \_\_\_\_\_.

The Qualifying Events was:

- reduction in work hours\termination of employment
- the employee's death
- employee's entitlement to Medicare
- divorce or legal separation
- loss of dependent child status due to age or marriage

Under the federal law and Connecticut law, you and your dependants are eligible to continue your group insurance coverage under our plan beyond the date that it would normally terminate.

**Under what circumstances may coverage not be continued?**

Continuation is not available to persons who:

- are entitled to Medicare or, under state law, are eligible for other group insurance
- become covered under another group plan (after electing to continue coverage) which has no pre-existing condition prohibitions which apply to that person
- are terminated due to gross misconduct

### **How long may an individual continue benefits?**

The period in which coverage may be continued depends on the qualifying event that lead to the loss of eligibility under the plan. Generally, coverage may be extended for 18, 29, or 36 months.

#### *18 Month Qualifying Events*

Continuation-of-coverage for up to 18 months is available to employees and their eligible dependents when group insurance terminates due to a reduction in work hours or termination of employment (other than termination due to gross misconduct.) This includes a reduction of hours followed by the termination of employment.

#### *29 Month Qualifying Events*

Individuals who are determined to be disabled under Title II (OSADI) or Title XVI (551) of the Social Security Act may have their continuation (and their dependents) extended from 18 to 29 months if the individual is disabled within 60 days of the continuation-of-coverage under COBRA or state law.

If the individual receiving 29 months of coverage is determined by Social Security to be no longer disabled, coverage will cease after the expiration of 18 months but before the expiration of 29 months. Coverage will end at the end of the month that begins 30 days after such a determination.

#### *36 Month Qualifying Events*

Spouses and/or dependent children may elect to continue coverage for up to 36 months for:

- Divorce or legal separation from the spouse
- Covered employee's death
- Covered employee's entitlement to Medicare
- Loss of dependent child status under the plan

If a spouse or child is receiving 18 months continuation because of an employee's termination of employment or reduction of work hours and a second qualifying event occurs, continuation may be extended to 36 months. In no instance will continuation be available more than 36 months from the date of the first qualifying loss of coverage.

### **When Does Continuation-of-Coverage End?**

A person ceases to be eligible to continue coverage on the first date any one of the following occurs:

- the maximum period of continuation-of-coverage to which the person is entitled ends
- the \_\_\_\_\_ ceases to provide the group plan
- the person stops paying premiums
- the person becomes covered under a group plan after electing coverage or becomes covered under another plan and the plan does not contain any pre-existing condition limitations that apply to that person
- the person becomes entitled to Medicare or, under state law, eligible for other group insurance

### **Is the coverage the same as I had before ?**

Group insurance benefits for a person electing to continue coverage are the same as those for active employees or dependents. Any change in benefits for active employees will also apply to persons who have continued coverage, provided they are not hospitalized at the time.

## **What am I required to pay?**

Individuals who elect to continue coverage will be required to pay the full premium for their coverage, including any portion previously paid by the \_\_\_\_\_. The premium is the same as the premium for active employees or dependents. However, the \_\_\_\_\_ is permitted to charge an additional 2% of the regular premium to cover administrative expenses. For a disabled individual who extends continuation from 18 months to 29 months, the \_\_\_\_\_ is permitted to charge an additional 50% of the regular premium for months 19 through 29. Premiums are subject to increase as with active employees.

## **What must my employer tell me/ What must I tell My employer?**

Federal COBRA law defines plan administrator, \_\_\_\_\_ and employee obligations for \_\_\_\_\_ of 20 or more employees. \_\_\_\_\_ are required to notify covered employees and their dependents of their continuation rights at the time they become insured and again at the time they qualify for continuation.

In the event of a divorce or legal separation, or a dependent child ceasing to be a qualified dependent by reason of age or marriage, the covered employee and his or her dependents must notify the \_\_\_\_\_ within 60 days of the qualifying event. Within 14 days of being notified, the plan administrator must provide the employee and his or her dependents with a form to elect continued coverage. The plan administrator is under the same obligation to provide an election form in the event of an employee's death, termination of employment or reduction of work hours. In the event an individual is determined to be disabled under the Social Security Act, the individual must provide notice to the plan administrator before the 18 month period expires, and within 60 days of the Social Security determination of disability in order to be allowed to extend coverage from 18 months to 29 months. If the individual is subsequently determined to no longer be disabled under the Social Security Act, the individual must provide notice to the plan administrator within 30 days of the final determination. Coverage will cease at the end of the month that begins 30 days after such a determination.

When an employee or dependent becomes eligible to continue coverage, the eligible employee or dependent must complete and sign the election form and return the form to the \_\_\_\_\_ within 60 days of its receipt. If an eligible person does not submit a completed form, it is assumed the eligible person has elected not to continue their group coverage. The individual will not be permitted to elect continuation at a later date. The first payment for continuation-of-coverage is due no later than 45 days following the date the individual makes the election. Monthly payments for the coverage the individual will receive following their election must be received no later than the first of each month.

## CONTINUATION-OF-COVERAGE

- - NOTICE - -

Employee/Dependent Name: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Date of Employment: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Termination of Your Coverage

Your  Medical,  Dental  Vision coverage will terminate on \_\_\_\_\_. However, you may elect to continue your  Medical,  Dental  Vision coverage that you currently have in force under the program beyond this date.

### Your Right of Continuation

Under federal law, you may elect to continue coverage during the 60 day period beginning on the later of the date your coverage otherwise would cease, or the date you receive this notice. If you elect to continue this coverage, you will be given the opportunity to change your coverage choices at the same time that active employees may change their choices.

### Period of Continuation-of-Coverage

The length of your continuation-of-coverage depends on the reason your coverage is terminated (i.e., the qualifying event):

- If loss of coverage is due to a reduction in your working hours or if you are laid off or otherwise terminate your employment voluntarily or involuntarily, except for gross misconduct, you and your dependents may continue coverage for a period of 18 months.
- If you are a covered dependent and termination of your coverage has resulted from a loss of dependent status, a divorce, the death of the covered employee or the covered employee's loss of coverage due to Medicare entitlement, your coverage may continue for a period of 36 months.
- If you are entitled to continue coverage for 18 months but are determined to be disabled under Title II (OSADI) or Title XVI of the Social Security Act within 60 days of your continuation-of-coverage under COBRA or state law, the 18 month period may be extended to a maximum of 29 months if you notify the plan administrator within 60 days of the determination.
- If a second qualifying event occurs during the 18-month coverage period (e.g., the death of the covered employee, loss of dependent status, divorce or the covered employee's Medicare eligibility), the original 18-month period may be extended to a maximum period of 36 months.

Your right to continue to receive this coverage will cease before the expiration of the full period if you become covered under another \_\_\_\_\_group health plan (after electing coverage) or become covered under another group plan and that plan has no pre-existing condition prohibitions that apply to you or, under state law, become eligible for coverage under another group plan. Coverage will also cease if you become entitled to Medicare, the \_\_\_\_\_terminates the health plan with respect to all employees, or you do not pay the premiums due for the selected coverage's on time. If you are disabled and receiving 29 months of coverage and Social Security determines you are no longer disabled after the expiration of 18 months but before the expiration of 29 months, coverage will cease at the end of the month that begins 30 days after such a determination.

### **Cost of Continuation-of-Coverage**

If you elect continuation-of-coverage, you must pay the full group premium cost of the coverages you select. You must also pay an additional 2% of the premium cost to help pay for the administration of your coverage. If you are disabled and eligible for 29 months of coverage, you must pay an additional 50% of the premium cost for any coverage beyond 18 months. The monthly costs of the coverages you currently have in force are Illustrated below:

**Monthly Premiums**

Medical Coverage	\$ _____
Dental Coverage	\$ _____
Vision Coverage	\$ _____
Total	

Your monthly cost will include only those coverages you elect to continue. To determine your total monthly cost, add the monthly cost of each coverage item you are electing plus an additional 2% or 50%. The first payment for continuation of coverage is due\*\* no later than 45 days following the date you make the election. Monthly payments for the coverage you will receive following your election must be received no later than the first of each month.

*\* Please note, these rates are subject to change and are not guaranteed for entire duration of your continuation-of-coverage.*

**I hereby acknowledge that I have received this Continuation-of-Coverage Notice, and that I understand my rights and obligations with respect to such coverages.**

Check One:

\_\_\_\_ I hereby elect to continue the following group coverages  
(Check appropriate blanks):

\_\_\_\_\_ Medical \_\_\_\_\_ Dental \_\_\_\_\_ Vision

\_\_\_\_ I hereby decline to continue my group medical insurance coverage. I understand that my decision is final at the conclusion of the election period, and that I will not be offered the opportunity to elect to continue my coverages at any future time.

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