#### COBRA Continuation Coverage Election

**Date of Notice: {Date of COBRA letter} QB: {Name of COBRA Qualified Beneficiary EE}**

***(For Termination or Reduction in Hours of Employment)***

**Qualified Beneficiary Information**

|  |
| --- |
| **Name: Last, First, Middle Social Security Number****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Home Address Street City State Zip****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of Birth: / / Marital Status: \_\_\_Single \_\_\_Married****No of Dependent Children:\_\_\_\_\_****Date of Hire: / / Policy Number:**  |

**Entitlement to COBRA Coverage**

As explained in the notice of rights accompanying this form, you and your spouse and dependent child(ren), if any, could be entitled to continue coverage under the company’s group health plan benefit plan(s) due to the following qualifying event:

**Qualifying Event: {Enter Qualifying Event}**

*This qualifying event will result in the loss of coverage under the group health plan unless you elect continuation coverage.* If you would like to elect continuation coverage, please read and sign this form and return it to the address below as soon as possible. If this election form is not returned by **{Date the election form is due},** which is 60 days from the date of this notice, you will lose your right to elect coverage, and your coverage under the company’s group health plan will terminate effective: **{Date coverage is canceled}**

Continuation coverage under COBRA is provided subject to your eligibility. **{Employer Name}** reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

**IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Length of COBRA Coverage**

You and your spouse and dependent child(ren), if any, are eligible to receive up to **18 MONTHS** of continuation coverage (less for Medical FSA coverage) from the date of termination or reduction of hours of employment. However, coverage may extend beyond that period or terminate early, as explained in your election notice.

**COBRA Coverage Premiums**

Within 45 days after the date that you elect COBRA coverage, you must pay an initial premium, which includes:

1. The period of coverage from the date of your qualifying event to the date of your election.
2. Any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period. Coverage will be reinstated retroactive to the date it originally ended.

After your initial premium payment, future payments for continued coverage will be due within 30 days after the first day of each month of coverage. If you fail to pay the initial premium, or any subsequent monthly premium, in a timely fashion, your coverage will terminate. Premium amounts change from time to time.

You will be notified of any change in the premium amount. The regular monthly cost of coverage will be as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Plan** | **Individual** | Two Person | **Family** |
| **{health plan employee is covered by}****{Policy Number}** | **{$single}** | **{$EE + spouse/child}** | **{$family}** |
| **{Medical FSA}** | **{Med FSA Monthly cost}** | **{Med FSA Monthly cost} times two** | **{Med FSA Monthly cost} times number of family members** |
| **{dental plan employee is covered by}****{Policy Number}** | **{$Single}** | **{$EE + spouse/child}** | **{$family}** |
| **{vision plan employee is covered by}****{Policy Number}** | **{$Single}** | **{$EE + spouse/child}** | **{$family}** |

|  |  |  |  |
| --- | --- | --- | --- |
| **{HRA plan employee is covered by}** | **{$Single}** | **{$EE + spouse/child}** | **{$family}** |

**IF PREMIUM PAYMENT IS NOT RECEIVED ON TIME,**

**COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED.**

**NOTE: *Due to the impact of COVID-19, if an individual experienced a qualifying event, had a COBRA premium payment deadline, or a deadline to notify the plan of a disability determination or other event between March 1, 2020 and February 28, 2021, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether a notification or payment is timely.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COBRA Coverage Election Agreement**

I have read this form and the notice of my election rights. I understand my rights to elect continuation coverage and would like to take the action indicated below. I understand that if I elect continuation coverage and I fail to pay any premium payment on time, this coverage will terminate. I also agree to notify **{Employer Name}** if I, or any member of my family, become(s) covered under another group health and/or dental plan or entitled to Medicare.

Please check those that apply:

🗆 I elect to continue *Family/Two Person* Health/Dental/Vision//HRA/Medical FSA (circle those that apply) coverage under the plan. (You may only cover qualified beneficiaries who had coverage before the qualifying event.)

List Dependents to be covered:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Plan (health/dental/vision/health FSA/HRA) | Relationship | **Soc. Security No.** | Date of Birth |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

🗆 I elect to continue *Individual* Health/Dental/Vision/Medical FSA/HRA coverage (circle those that apply) under the plan (only for those who had coverage under the plan).

Important note: **{Employer Name}** will accept photocopied reproductions of this election form in case each or any qualified beneficiary in your family wants to elect separate individual coverage. If all of the qualified beneficiaries to whom this letter has been sent wish to be covered under the plan as a family unit, then only one person (guardian) has to complete and sign up for Family coverage on everyone’s behalf.

 ***I hereby certify that, in addition to completing this form, I have received Life Insurance Conversion information from {employer name}. I understand it is up to me to contact the carrier if I want to convert my Life Insurance.***

**🖊**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

 Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Make Checks Payable to: **{Employer Name}**

Send form to: **{Employer contact}, {Employer Name}, {Employer Address}**

Inquiries should be directed to: **{Employer Contact}** at **{Employer contact phone number}**

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