PIBT | PRINTING INDUSTRIES BENEFIT TRUST
5800 South Eastern Avenue, Suite 400 • Los Angeles, CA 90040
Phone: (323) 728-9500 • Fax: (323) 722-7386
Northern California/San Diego Phone: (800) 479-7837

CAL-COBRA
BENEFIT TRUST

Name _____ Date _____

Social Security # _____

Re: Continuation of Coverage

Your coverage under the PIBT provided through _____ (Employer)

will terminate/has terminated as of _____ (Date) Under the provisions of the Plan you have the option to continue the group health coverage up to the time period specified below:

Persons Qualified to Continue Coverage

	Maximum Coverage Period
☐ Employees whose employment was terminated (other than for gross misconduct) and their spouses and dependent children	36 months
☐ Employees whose hours have reduced to the extent they no longer meet the Plan's eligibility requirements and their spouses and dependent children	36 months
☐ Spouses and dependent children of deceased, divorced, or legally separated employees	36 months
☐ Spouses of employees eligible for Medicare	36 months
☐ Dependent children whose coverage terminates due to the Plan's eligibility rules	36 months
☐ Employee's termination or reduction of hours due to a disability	36 months

You have 60 days from the date of termination of your coverage, or 60 days from the date of this notice, if later, to make this election. The following monthly cost of this coverage (subject to premium charge) under the continuation provision includes a 10% administration fee (50% in certain cases of disability) in addition to the regular group premium.

	Medical	Dental	Vision
Employee	$ _____	$ _____	$ _____
Dependent	$ _____	$ _____	$ _____
Employee and Dependents	$ _____	$ _____	$ _____

Premiums are retroactively billed to termination date. Initial payment for the total amount due must be made within 45 days of the date you postmark your election to continue coverage under COBRA.
Coverage will terminate if:

- You elect to discontinue coverage;
- You fail to pay the applicable premium when due;
- You become eligible for Medicare or another group health plan;
- Your employer under whose plan the continuation is provided no longer maintains a group health plan.
- You cease to be disabled after 18 months of COBRA coverage.

Please complete the attached Election Form indicating whether or not you wish to continue coverage and mail it to the address indicated.

To: PIBT, Attn: COBRA Department
P.O. Box 910936, Los Angeles, CA 90091-0936

ELECTION FORM – FOR CONTINUATION OF GROUP HEALTH COVERAGE

I have read this Election Form and the COBRA Rights & Rules booklet. I understand my right to elect continuation coverage and would like to elect the coverage 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 the Plan Administrator if I or any member of my covered family members become covered under another group health plan or entitled to Medicare after the date of my COBRA election. In the event I receive an 11-month extension of COBRA continuation coverage resulting from a disability, I agree to notify the PIBT within 30 days of a determination that the disabled person is no longer disabled.

☐ Employee's Social Security # _____

☐ I elect to continue group coverage under the PIBT Plan as indicated below and agree to pay the required premium.

☐ Employee coverage only. ☐ Employee and Dependent coverage.

☐ Dependent coverage only: Dependent's Social Security# _____

☐ I do not wish to continue coverage under the PIBT Plan.

Name: _____

Address: _____ Phone: (____) _____

Name of Employer: _____

Signature: _____ Date: _____

WHITE – Covered Person Copy PINK – Employer Copy YELLOW – PIBT Copy