COMPANY NAME: _____ (The Company)

COBRA Continuation Coverage
Notice & Election Form

Notice Date: _____ / _____ / _____

From: _____ (Company & Benefit Administrator)

To Qualified Beneficiaries:

- ❑ Employee / Former Employee
- ❑ Spouse / Former Spouse
- ❑ Dependents
- ❑ Child no longer qualifying as dependent

Qualifying Event:

- ❑ End of Employment
- ❑ Death of Employee
- ❑ Entitlement to Medicare
- ❑ Reduction in hours/employment
- ❑ Divorce or legal separation
- ❑ Loss of dependent child status

COBRA Dates
Due to the qualified event, occurring _____ / _____ / _____, you are eligible for COBRA coverage beginning on _____ / _____ / _____. Your existing coverage ends as of _____ / _____ / _____, unless you elect COBRA coverage.

COBRA Health Coverage Costs per Month $_____

For your current Medical Election:

- ❑ Employee ONLY
- ❑ Employee + Spouse
- ❑ Employee + Child/ren
- ❑ Employee + Family

This notice contains important information about your rights to continue your health care coverage in the Company's group health plan (the 'Plan').

If you are married, both you and your spouse should read this Notice and review the Election Form. If your spouse and/or any dependent child does not live with you, you must advise the Plan Administrator (listed below) immediately of his, her, or their address(es) so we can provide them with this Notice and Election Form.

Because of the Qualifying Event specified above, your coverage under the Plan has ended or will end shortly. Federal law (known as COBRA) permits you and your covered dependents to elect to continue your company's health plan coverage for a limited time. This coverage is called "continuation coverage" or "COBRA" coverage. You and your dependents, if any, are sometimes called "Qualified Beneficiary" in this Notice.

COBRA Continuation Coverage
Continuation coverage consists of the same coverage under the Plan that you and your other qualified beneficiaries had immediately before your qualifying event. ***COBRA Continuation Coverage is the same coverage that the Plan gives to other participants or qualified beneficiaries under the Plan who are not on COBRA.*** If the Company's group health plan changes providers, benefits, premiums, etc., continuation coverage changes accordingly. During open enrollment, each qualified beneficiary will have the same options under COBRA coverage as active employees covered under the company's group health plan.

Maximum Coverage Periods
COBRA coverage generally continues up to 18 months.

1. Coverage due to the end or employment or reduction in hours may be continued up to a total of 18 months.
    a. When the qualifying event is the end of employment or reduction of the employee's hours, and there is a death, divorce, or a dependent child ceasing to qualify as a dependent, you, must notify us within 60 days in order to extend from 18 months to 36 months.
    b. When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare benefits less than 18 months prior to the qualifying event, COBRA coverage for qualified beneficiaries (other than employee) may be continued up to 36 months from the date of Medicare entitlement.
2. Coverage due to employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits, or a child ceasing to qualify as a dependent under the Plan may be continued up to 36 months.
3. Coverage may be extended to 29 months if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be permanently disabled. The disability must start within the first 60 days of COBRA and it entitles all covered dependents to the extension. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan within 30 days after SSA's determination.

This notice shows the maximum periods of continuation coverage available to qualified beneficiaries.

Early Termination of COBRA Coverage
COBRA coverage can terminate before the period described above expires. Early termination of COBRA coverage for a qualified beneficiary terminates on the earliest of:

1. The month for which the premium for COBRA coverage is not paid in full and on time;
2. The date the company ceases to maintain any group health plan;
3. The date the qualified beneficiary becomes entitled to (a) Medicare or (b) coverage by another group health plan that contains no exclusion or limitation for pre-existing conditions of the Qualified Beneficiary, or which exclusion or limitation does not apply due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
4. If a Qualified Beneficiary is entitled to 29 months of COBRA coverage on account of disability, but is later determined not to be disabled, coverage ends with the first month beginning more than 30 days after that determination.
5. For any reason the Plan would terminate coverage of a participant or qualified beneficiary not receiving continuation coverage (such as fraud).

How to Elect to Continue Health Plan Coverage
You or any qualified beneficiary may elect to continue coverage by completing the attached COBRA Election Form and returning it to: _____
within the election period described below**.** Your covered dependents also have the right to elect coverage for themselves. This means that even if you don't elect to continue coverage for them, they may independently elect to continue their coverage.

Election Period
_____ must receive the completed COBRA Election Form on or before the date specified on the election form. The election period ends 60 days after the date of this Notice or 60 days after the qualifying event, whichever period is longer. ***If we don't receive the election form by the date specified on the COBRA Election Form, neither you nor any of your qualified beneficiaries will be entitled to COBRA coverage.***

COBRA Coverage Premiums
You must pay the entire premium for the elected COBRA coverage(s) for all qualified beneficiaries. See the attached Medical Premium Schedule for rates. The rates include a 2 percent mark-up (or a 50% mark-up due to a disability extension) allowed by COBRA to cover administrative expenses. These rates are subject to change once a year as of the beginning of the "determination year" as indicated on the schedule. If you are on COBRA and you become disabled, you will be required to retroactively pay the 'Cobra with Disability rates' to the month in which you became disabled.

COBRA Payments
You must pay the premium payments for your "initial premium month(s)" by the 30th day after you elect coverage. All other premiums are due on the 1st of the month for each covered month.

For example, Joe's coverage ended September 30th. He elects coverage November 20th, and his initial payment (for October, November and December) is due by December 20th (30 days from his initial election of COBRA). His January payment is due on or before January 1st.

- The Plan will not send notices of payments due for COBRA coverage.
- If the full initial premium payment is not made within the 30-day grace period, COBRA coverage for the affected qualified beneficiaries will be canceled effective the last month for which a full premium was received.
- If you fail to make a timely payment, you will lose all rights to continuation coverage under the Plan.
- No claims under the group health plan incurred after the qualifying event will be paid until the applicable premium is paid.
- If, for whatever reason, you received any benefits under the Plan during a month for which the premium was not paid timely, you are required to reimburse us for the benefits you received.

For further information
If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, please contact the Company's Plan Administrator:_____ _____ at (___) _____-_____ or at the following address: _____ _____.

COBRA Continuation Coverage
Election Form

This form must be completed and returned to the address listed below within 60 days of (a) the date you were notified of your COBRA Continuation rights or (b) the date you lost employer provided coverage, whichever is later. If you are electing COBRA you must also complete and return the appropriate PacifiCare and Principal COBRA forms.

Please make monthly checks payable to:
and send to:

Attn: _____

_____
Name of Individual

_____ _____ _____ _____
Address City State Zip

(____) _____ _____
Telephone Social Security # (SSN)

Only those individuals that had coverage immediately before the qualifying event, may be covered under COBRA. See attached Medical Premium Schedule for rates.

Medical Monthly Cost: $_____

- ❑ I / we elect to continue medical coverage for the following individuals:

Name	Date of Birth	Relationship to Employee	SSN
1.			
2.			
3.			
4.			
5.			
6.			

- ❑ I / we **DO NOT** elect to continue medical coverage for the following individuals:

Name	Date of Birth	Relationship to Employee	SSN
1.			
2.			
3.			
4.			
5.			
6.			

COBRA Continuation Coverage
Election Form Continued

Dental Monthly Cost: $_____

- ❑ I / we elect to continue dental coverage for the following individuals:

Name	Date of Birth	Relationship to Employee	SSN
1.			
2.			
3.			
4.			
5.			
6.			

- ❑ I / we **DO NOT** elect to continue dental coverage for the following individuals:

Name	Date of Birth	Relationship to Employee	SSN
1.			
2.			
3.			
4.			
5.			
6.			

Your covered dependents also have the right to elect coverage for themselves. If you decline coverage for them now, they will lose all rights to COBRA continuation coverage under the Plan.

I understand that monthly premiums are due in full on the first day of the month. If premiums are not received by the first day of each month, all coverage is subject to cancellation if not paid within the grace period discussed in the attached COBRA notice.

_____ _____

Signature Date