

SAMPLE COBRA ELECTION NOTICE

Date: _____
To: _____
Address: _____

On _____, your group coverage, and that of your spouse and dependent child(ren), if any, under the City of _____'s group plan will terminate because of the following:

- Termination of employment
- Reduction in hours of employment

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, this is a QUALIFYING EVENT that will entitle you and your spouse and dependent child(ren), if any, to elect to continue coverage (referred to as "COBRA coverage") under the plan for up to 18 months after your qualifying event.

To continue coverage, you must complete and submit the attached election form to the City by: _____ (sixty (60) days from the date of this notice).

This same notice is being sent separately to your spouse, if any; however, only one of you needs to elect continuation coverage for any family members wishing to continue coverage (both employee and spouse do not need to elect coverage if coverage will continue for all covered family members). Furthermore, because COBRA gives you the right to elect coverage independently, you, your spouse or dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage. (Continuation coverage is only available to family members currently enrolled.)

The monthly premium due for COBRA coverage is shown on the attached election form. To be sure enrollment is complete, you should pay the total premium amount due at the time you send in the election form. However, you are allowed to delay the premium payment for up to forty-five days after you have signed, dated and submitted your election form.

Future premiums are due each month thereafter. Failure to pay premiums by the due date may terminate your participation in COBRA coverage.

Early Termination of COBRA Coverage

Your COBRA coverage may be terminated early for a number of reasons, including:

- You do not pay the required premium on time.
- After the date of your COBRA election, you become covered under another group health plan that does not contain any exclusion or limitation for any of your pre-existing conditions.
- After the date of your COBRA election, you become entitled to Medicare benefits.
- The City's group plan is terminated.

If you have any questions, please contact the following city representative:

Name: _____

Phone #: _____

BENEFITS CONTINUATION PLAN ELECTION FORM

Date of Notice _____

City of: _____

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:	/ /				

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 health coverage under the City's group health plan due to the following qualifying event, which took place on _____:

- Termination of employment
- Reduction in hours of employment

This qualifying event will result in the loss of coverage unless you elect continuation coverage. If you would like to elect continuation coverage, please read and sign this form and return it as soon as possible. If this election form is not returned within 60 days of the date of this notice, you will lose your right to elect coverage, and your coverage under the City's group plan will terminate effective: _____.

Continuation coverage under COBRA is provided subject to your eligibility. The City reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for 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 from the last effective day of your group coverage. COBRA coverage period: _____ to _____.

COBRA Coverage Premiums

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

- The period of coverage from the date of your qualifying event to the date of your election.
- Any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period.

If you fail to pay the initial premium, or any subsequent monthly premium, in a timely fashion, your coverage will terminate. The City recommends you mail your initial premium payment with your election form.

Premium payments are due within 30 days after the first day of each month of coverage. Premium amounts change from time to time. You will be notified of any change in the premium amount.

COBRA Premium Schedule

Continuation of Coverage Under the City of _____

Monthly Premium

Qualified Beneficiary	Medical Plan	Dental Plan
<ul style="list-style-type: none">• Covered Employee Only• Spouse or Ex-Spouse Only• Dependent Child Only	\$ _____	\$ _____
<ul style="list-style-type: none">• Covered Employee and Spouse	\$ _____	\$ _____
<ul style="list-style-type: none">• Covered Employee and One or More Dependent Children• Spouse or Ex-Spouse and One Or More Dependent Children	\$ _____	\$ _____
<ul style="list-style-type: none">• Covered Employee, Spouse and One or More Dependent Children	\$ _____	\$ _____

KEEP THIS COBRA PREMIUM SCHEDULE FOR YOUR RECORDS.

**IF PREMIUM PAYMENTS ARE NOT RECEIVED ON TIME,
COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED.**

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 the City if I, or any member of my family, become(s) covered under another group plan after the date of COBRA election.

Please check ONE only.

- I elect to continue family coverage under the plan.** (List eligible persons to be covered: PERSONS PREVIOUSLY COVERED ONLY.)

NAME					
LAST	FIRST	MIDDLE	BIRTH DATE	SEX	SOC. SEC. #
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

- I elect to continue single coverage under the plan.**
- I have read this form and the notice of rights. I am waiving my right to continuation coverage under the plan.**

Signature: _____ Date: _____

Telephone: _____

Return this election form and initial premium payment to: _____

Make checks payable to: _____

Election form due date: _____