

## Qualifying Event Forms Packet (Pkt01)

This packet contains form for use following a qualifying event that is:

- A) Termination of Employment.
- B) Reduction of hours of employment.

Packet Contents:

- 1) Qualifying Event Cover Letter (WI03).
- 2) Qualifying Event Notice (Qe01).
- 3) Election Notice (Fel01).

ERISA Section 606(c) requires the plan administrator to notify a qualified beneficiary of their COBRA rights within 14 days after the plan administrator is notified by the employer that a qualifying event has occurred.

NOTE: When the employer is also the plan administrator, the employer must provide notice to the qualified beneficiary within 44 days of the qualifying event date, or the date coverage is lost, whichever is later.

The above listed notices were sent to the following:

<b>Date of Notice</b>	
<b>Name of Individual(s)</b>	
<b>Address</b>	
<b>City, St, Zip</b>	
<b>Notes:</b>	

## Important Notice Regarding Your Health Coverage (WL03)

The enclosed materials contain important information regarding your rights to continue your health coverage, including premiums, election procedures, and due dates. If you have any questions about your rights, or need information on how to act on behalf of an incompetent beneficiary, please contact the plan administrator listed on the bottom of this page.

### Individual Information

Name of Individual		Name of Employee	
Address of Individual		City, St, Zip	
Date of Notice		Social Security#	

### Important Information

Type of Qualifying Event:			
Qualifying Event Date		Benefits Termination Date	
Election Rights Termination Date			

The following individuals are entitled to elect COBRA continuation coverage:

Name	Relationship	

If you choose to elect continuation coverage, please complete the enclosed election form. If you meet all other requirements your coverage will continue with no lapse in coverage. If this office does not receive the election form by the election expiration date, you forfeit all rights to COBRA continuation coverage.

Coverage/Plan Type	Single	Single +1	Empl + Child	Family	

If you have any questions, please call:	
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**Important Information**  
 Regarding Your Rights to COBRA Continuation Coverage  
 (Qualifying Event Notice for Termination of Employment or Reduction of  
 hours of employment)

Company Name		Address	
Name of Individual		Address	
Date			

Under the terms of the Consolidated Omnibus Reconciliation Act of 1985 (**COBRA**), former covered employees and their eligible dependents have the right to temporarily continue coverage under the sponsoring employer's group health plan for up to 18 months if coverage terminates due to a **Qualifying Event** that is:

- 1) *Termination of employment, including voluntary resignations, involuntary termination, retirement or layoff, except for termination due to gross misconduct.*
- 2) *Reduction of hours worked, including work stoppage, strike, or leave of absence.*

A **Qualifying Event** is any of the above events that would cause an employee, former employee, covered spouse, or covered dependent child to lose coverage under the sponsoring employer's group health plan. An employee, former employee, spouse or dependent child who lost coverage due to a Qualifying Event and was covered on the Plan the day before the Qualifying Event is known as a **Qualified Beneficiary**. A child born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will also be considered a Qualified Beneficiary. Qualified Beneficiaries are entitled to continue the same group health coverage in effect on the day before the Qualifying Event. This may include medical, dental, vision, prescription drug benefits and certain Health Flexible Spending Accounts (FSA's). COBRA continuation coverage does not extend to Life Insurance, Accidental Death and Dismemberment, or Disability Benefits. You are entitled to COBRA continuation coverage even if you have other health coverage, including entitlement to Medicare, as long as this coverage was in effect **prior** to electing COBRA continuation coverage.

**Electing COBRA Continuation Coverage**

Enclosed is an Election Form that must be completed by you if you wish to continue coverage for yourself and/or your eligible spouse and/or eligible dependent children. In order for your election to be considered "timely" and valid, the Election Form must be postmarked, or received, by the Plan Administrator within 60 days from the later of the a) Benefits Termination Date, or b) the date of this notice, whichever is later. Each Qualified Beneficiary is entitled to make an Independent Election of any benefit plan for which they are eligible. If you elect continuation coverage, you are entitled to receive the same level of benefits as similarly situated nonCOBRA beneficiaries. Changes to plan benefits may be modified in accordance with Federal COBRA regulations. A separate Election Form must be completed for Qualified Beneficiaries who wish to make an Independent Election. Please contact the Plan Administrator for additional forms. Coverage may also be

electd for children born to or placed for adoption with a covered employee during the period of the Qualified Beneficiary's continuation coverage in accordance with the Plan's enrollment rules. Contact the Plan Administrator if this applies to you.

**Duration of Continuation Coverage**

For Qualifying Events that are the termination of employment or reduction of hours, the period of COBRA continuation coverage may be continued for 18 months, measured from the date of the Qualifying Event. If the Qualified Beneficiary makes a timely election, COBRA continuation coverage will be effective on the day after the date that coverage would otherwise end. You do not have to show evidence of insurability to be entitled to continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage under the Plan. The sponsoring employer reserves the right to terminate continuation coverage retroactively if you are determined to be ineligible for coverage. If coverage is terminated, it cannot be reinstated. You must notify the Plan Administrator if you or a family member becomes covered under any other group health plan, or becomes entitled to Medicare benefits during the continuation period. Coverage may be terminated prior to the maximum coverage period for any of the following reasons:

- 1) *Payment of premium is not made in a timely manner.*
- 2) *If all group health plans maintained by the sponsoring employer are terminated.*
- 3) *A participant becomes entitled to Medicare after the date of election.*
- 4) *A participant becomes covered under another group health plan, and that plan does not contain any applicable pre-existing condition exclusion.*

**Payments for Continuation Coverage**

The initial premium payment for continuation coverage must be made within 45 days of the date the election is made. Payment is considered made on the date sent. Payments are considered timely if a) postmarked by the U.S Postal Service on or before the applicable grace period expiration date, and received by the Plan Administrator, b) sent by an express delivery service (with proof) that payment was sent on or before the applicable grace period expiration date, or c) delivered in person to the Plan Administrator during normal business hours. Late payments will not be accepted and will result in termination of coverage with no possibility of reinstatement. The initial payment must include premiums due for all months from the Benefits Termination Date through the date of your payment. Subsequent premium payments are due on the due date, and must be made within the 30-day grace period. The Plan

**Important Information**  
Regarding Your Rights to COBRA Continuation Coverage  
(Qualifying Event Notice for Termination of Employment/Reduction of hours)

Administrator may provide payment vouchers upon receipt of the Election Notice. However, you are responsible for making the monthly payments in a timely manner even if you fail to receive the payment vouchers.

**Premium Rates for Continuation Coverage**

The cost for continuation coverage is the applicable premium for coverage elected, plus an administrative fee, if applicable. Please refer to the enclosed COBRA rate sheet. A Qualified Beneficiary who is determined to be disabled (under Title II or XVI of the Social Security Act) at the time of the Qualifying Event or within the first 60 days of continuation coverage, may be charged up to 150% of the applicable premium during the disability extension period. If only non-disabled Qualified Beneficiaries are covered during the extension period, the applicable premium, plus administrative fee (if applicable) will apply. If you wish to make a payment at the time of the election, make certain that the check is signed, dated, made out to the sponsoring employer, and the total is the amount required to fully pay your premium.

**Disability Extension**

A Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act, to have been disabled at the time of the Qualifying Event that is a termination of employment or reduction of hours, or within the first 60 days of continuation coverage for all Qualified Beneficiaries, may be eligible for an additional 11 months (for a total of 29 months) of continuation coverage. A written determination of disability from the Social Security Administration must be provided to the Plan Administrator within 60 days of the determination of disability. The notice must be provided prior to the end of the 18-month continuation period. The sponsoring employer may charge up to 150% of the applicable premium for continuation coverage during the 11-month disability extension period. If the Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled under Title II or XVI, the Qualified Beneficiary must notify the Plan Administrator within 30 days of the determination.

**Claims**

Claims are paid for each period of coverage only after a premium payment for the coverage period is made. Payment of claims may be delayed because of the time required to process your initial premium payments by your sponsoring employer and group health carrier. If you have claims, contact the Plan Administrator or the group health carrier's claims office. Payments not made in a timely manner will result in a cancellation of coverage retroactively with no possibility for reinstatement. Claims incurred during the period for which payment has not been made will not be paid by the group health carrier.

**Inquiries from Health Care Providers**

The plan is required to make a complete response to inquiries from a health care provider regarding the Qualified Beneficiary's

right to coverage under the plan during the election period. The plan is also required to disclose, to health care providers, the status of continuation coverage during any applicable premium payment grace periods.

**Conversion Option**

If the Qualified Beneficiary's COBRA continuation coverage ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such an option is not otherwise generally available, it will not be made available to Qualified Beneficiaries.

**HIPAA and Open Enrollments**

Qualified Beneficiaries are entitled to the same open enrollment rights as nonCOBRA beneficiaries. HIPAA requires that group health plans provide special enrollment rights to add coverage for newly acquired family members. In addition, special enrollment rights must be extended to certain individuals who previously declined continuation coverage due to other coverage to enroll in the plan.

**Who to Contact:**

This notice does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the plan administrator. Payments should be sent to the above listed address. If you have questions regarding your rights under COBRA, please contact:

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## Election Agreement to Continue Group Health Coverage (Fel01)

**Applicant Information:** Please complete this form to elect COBRA continuation coverage. For assistance, or if you are electing for an incompetent beneficiary, call the Plan Administrator.

### Applicant Information

Employer Name		Applicant Name		Phone	
Address			Date of Birth		
Social Security#			Name of Plan:		
			<b>Gender M / F</b>		
Self		Spouse		Former Spouse	
			Dependent Child		Former Dependent Child
Do you wish to continue with a Flexible Spending Account, (FSA) if applicable? (Circle yes or no)			YES	Monthly Amount	\$ <span style="background-color: #e0ffff;"></span> NO
Plan Code/Coverage Type (Medical, Dental, etc.)				<b>Premium Amount</b>	\$ <span style="background-color: #e0ffff;"></span>

### Dependent Information

<b>Dependent Name</b>	Date of Birth	Gender	Relationship
<b>Social Security #</b>		M or F	Spouse or Child
<b>Dependent Name</b>	Date of Birth	Gender	Relationship
<b>Social Security #</b>		M or F	Spouse or Child

**IF NEEDED, ATTACH SEPARATE SHEETS FOR ADDITIONAL DEPENDENTS.**

I authorize the above election for continuation coverage (COBRA). I certify that I am electing only those coverage's that were in effect on the day before the qualifying event. I understand that I will no longer be eligible for COBRA continuation coverage if I fail to make timely premium payments, become entitled to Medicare, or become covered under another group health plan that does not contain a limitation or exclusion for a pre-existing condition. I also understand that I am responsible for making monthly premium payments even if I do not receive a billing statement and that failure to make timely payments will result in cancellation of continuation coverage with no chance for reinstatement. I also agree to notify the plan administrator of any changes in the address, eligibility, disability, or dependent status. I certify that the above statements are true to the best of my knowledge and that I have read the additional information with this form. Important: This form must be sent within 60 days of the benefits termination date, or date of this notice, whichever is later. The initial premium payment is due within 45 days of the date this election form is sent.

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