

**ACKNOWLEDGEMENT / ELECTION OF COBRA / CONTINUATION RIGHT:**

DATE: \_\_\_\_\_ EMPLOYEE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

On \_\_\_\_\_ (date), your group coverage, including spouse and child(ren), of (Employer Name) \_\_\_\_\_ group plan will terminate because of the following:

**QUALIFYING EVENT:**

_____ Date of Employment Ended	_____ Date Employee Passed Away
_____ Date Employee Reduced Hours	_____ Date of Divorce / Separation
_____ Date Employee Elected Medicare as Primary	_____ Date Child became Ineligible

At this time, you are eligible to elect COBRA – Consolidated Omnibus Budget Reduction Act of 1985 due to the qualifying event listed above. COBRA gives employees (of companies that employ 20 or more employees) the right to continue group medical insurance coverage at their own expense, when the employee's plan ends. COBRA coverage is only available for family members currently enrolled.

- COBRA lasts 18 months when the employment ends for any reason other than gross misconduct, when you as the covered spouse and the covered employee get divorced or legally separated, when your hours are reduced below the minimum necessary to qualify for group coverage or when you become eligible for medicare.
- COBRA lasts 36 months when the covered employee passes away, if you are the spouse or child of the employee and if a child is past the student status age.
- NEW YORK STATE CONTINUATION: NYS Continuation is (COBRA) for employers who have less than 20 employees - same rules as above apply.

**COBRA CONTINUATION ELECTION:**

To continue COBRA coverage, you MUST complete and submit the attached form to the Company and Address below:

\_\_\_\_\_  
Please Print Your Company Name and Address Above

**PREMIUMS AND PAYMENT:**

The monthly premium for COBRA is shown on the election form attachment. To ensure your enrollment is complete, please pay the total premium by check payable to \_\_\_\_\_ (employer name) and send it with your COBRA election enrollment form. You are allowed to delay the payment for up to 45 days after you have signed, dated and submitted your election form. However, after the 45 day grace period, your COBRA coverage is null and void. Future premiums are due each month thereafter. Failure to pay premiums by the due date will result in the termination of your COBRA coverage.

**COBRA PAYMENT SCHEDULE:**

Single Employee – Single Spouse – Single Dependent Child:	\$ _____
Employee & Spouse Coverage – No Dependent Children:	\$ _____
Employee & Child(ren) – Spouse & Child(ren):	\$ _____
Full Family Coverage – Employee, Spouse & Children:	\$ _____

**EARLY TERMINATION OF COBRA COVERAGE:**

Your COBRA coverage may be terminated early due to the following:

- You do not pay the required premium on time.
- After the Date of your COBRA election, you become covered under another group health plan
- After the date of your COBRA election, you become entitled to Medicare benefits.
- Your above Employer has terminated their group plan.

**COBRA COVERAGE ELECTION FORM:**

**COMPANY INFORMATION:**

Employer Name & Address: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

**MY INFORMATION:**

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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Employee: \_\_\_\_\_

Spouse: \_\_\_\_\_

Dependents: \_\_\_\_\_

Dependents: \_\_\_\_\_

Dependents: \_\_\_\_\_

**QUALIFYING EVENT:**

_____ Date of Employment Ended	_____ Date Employee Passed Away
_____ Date Employee Reduced Hours	_____ Date of Divorce / Separation
_____ Date Employee Elected Medicare as Primary	_____ Date Child became Ineligible

**COBRA ELECTION / REFUSAL:**

**ELECTION:**

**REFUSAL:**

\_\_\_\_\_ I wish to continue Employee Only

\_\_\_\_\_ I do NOT wish to continue Employee Only

\_\_\_\_\_ I wish to continue Employee & Spouse

\_\_\_\_\_ I do NOT wish to continue Employee & Spouse

\_\_\_\_\_ I wish to continue Employee & Children

\_\_\_\_\_ I do NOT wish to continue Employee & Children

\_\_\_\_\_ I wish to continue Full Family

\_\_\_\_\_ I do NOT wish to continue Full Family

**COBRA PAYMENT SCHEDULE:**

Single Employee – Single Spouse – Single Dependent Child: \$ \_\_\_\_\_

Employee & Spouse Coverage – No Dependent Children: \$ \_\_\_\_\_

Employee & Child(ren) – Spouse & Child(ren): \$ \_\_\_\_\_

Full Family Coverage – Employee, Spouse & Children: \$ \_\_\_\_\_

**ACKNOWLEDGEMENT / SIGNATURE:**

PLEASE KEEP A COPY OF THIS TWO PAGE AGREEMENT FOR YOUR RECORDS. I acknowledge that I have received and read the attached notice which explains COBRA and my rights of continuation. I understand that if I elect COBRA the payment of premiums is my sole responsibility. I further understand that if my premium is not received within 31 days of my premium due date, my coverage will automatically be terminated as of the last day of the period for which the premium was paid.

X  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date