

Sample Notice And Election Forms For COBRA Notification Requirements

EXHIBIT 2

NOTICE OF AVAILABILITY

Date

Employee's (and spouse's) Name
Street Address
City, State, Zip Code

Social Security No.
Employee I.D. No.

The health care coverage provided by [Company Name] to you and to any of your dependents ends on [month, day, year]. [For spouse or dependent events only: *the date when you were legally separated or divorced, or were no longer a qualified dependent as required under the [Company Name Employee Health Care Plan], or lose coverage under the [Company Name Health Care Plan] because your spouse or parent died or became covered under Medicare.*] However, as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may elect to continue the health plan coverage in which you and your dependents currently are enrolled, [name and number of plan option], and pay the applicable monthly premiums.

If you elect to extend your coverage, the benefits may continue for 18 [36] months but may end sooner when one of the following events occurs:

- You, or a covered dependent, become covered under any group health plan and that plan's preexisting medical conditions exclusions or limitations do not apply or are satisfied by you, or a covered dependent.
- You, or your covered dependent, become covered by Medicare.
- You fail to pay on time the monthly charge for this coverage.
- [Company name] no longer sponsors any employee health plan.

[For 18-month events only: *You, and/or covered dependents, may be able to extend COBRA coverage from 18 months to 29 months, if before the end of the 18-month COBRA coverage period, the Social Security Administration determines that you, or a covered dependent, have been disabled at any time during the first 60 days of continuation coverage. The coverage extension is available together or individually to the disabled individual and to the individual's nondisabled family members who are entitled to COBRA continuation coverage. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18-month period for coverage that includes the disabled individual. To qualify for the extension, you must submit a copy of the Social Security disability determination within 60 days of the date of the notice and before the end of the 18-month COBRA coverage period to [Name and address of responsible individual].*

The monthly charge for continuation coverage is as follows:

	Medical & Dental Coverage	Medical Coverage Only	Dental Coverage Only
For individual coverage	[\$\$\$]	[\$\$\$]	[\$\$\$]
For individual and spouse	[\$\$\$]	[\$\$\$]	[\$\$\$]
For individual and children	[\$\$\$]	[\$\$\$]	[\$\$\$]
For family	[\$\$\$]	[\$\$\$]	[\$\$\$]
[This may be modified to accommodate other medical options]			

Your first payment will be for the period beginning on [month, day, year active employee coverage terminates] through the end of the month in which you submit payment.

Your first payment must be received no later than 45 days from the date when you return the attached election form for processing. Subsequently, you must submit your monthly premium in full by the first day of each month, but no later than 30 days after the due date. You will mail your payments to the person and address listed on your copy of the attached election form. You will not receive any subsequent billing notices. [Alternately: *You will be billed monthly. Each bill will indicate the amount due, the due date, and where to send your payment. Or, You will receive a coupon book with monthly billing statements.*]

If your first payment, or any subsequent payment, is not received timely, you will lose your option to continue coverage. Payments must be for the full amount of the required premium. Coverage is provided only when the full premium for the applicable period is received.

If you wish to continue coverage, please complete both copies of the attached election form. Keep one copy for your records and return the other copy as indicated on the form. If you do not wish to continue coverage for yourself, your covered spouse and/or children may elect to continue their coverage on their own. To continue your health care coverage, and/or your spouse or children's coverage, send the following as indicated on the election form:

1. Your completed coverage continuation election form by [month, day, year], 60 days after the date of this notice;
2. Your first payment no later than 45 days following the date you return the election form.

If you have any questions, please call [name of responsible person] at [phone number].

Sincerely,

Enc.

EXHIBIT 3

COBRA CONTINUATION OF HEALTH CARE

COVERAGE ELECTION FORM

IMPORTANT:

If you wish to continue your health care coverage we must receive:

- 1. A completed copy of this election form by [insert deadline date], within 60 days of the date of our initial notice to you;*
- 2. Your first payment no later than 45 days following the date you return this election form. Your first payment will be for the period beginning on [month, day, year active employee coverage terminates] through the end of the month in which you submit your payment. Subsequent monthly premiums are due on the first day of each month, but no later than 30 days after that.*

Coverage is provided only when the full premium for the applicable period is received.

I wish to continue coverage under [Company Name's Health Plan] as follows (Select one option. Each individual for whom coverage is to be continued must have been insured under [Company Name] health plan on [month, day, year immediately before the qualifying event]): [The following options may be modified as necessary for varying options, i.e., medical only, or medical and dental, or dental only.]

- 1. For myself only (Monthly premium amount—[\$\$\$]).
- 2. For myself and my dependent(s) (family coverage) (Monthly premium amount—[\$\$\$]).
- 3. For the following individual(s) only, as listed below under "Dependents To Be Covered." (Monthly premium amount —[\$\$\$] per individual, or [Family Rate]).

DEPENDENTS TO BE COVERED: Please print below the full name, date of birth, and relationship to employee of each individual for whom coverage is being continued.

NAME/ SOCIAL SECURITY NUMBER	DATE OF BIRTH (MONTH, DAY, YEAR)	RELATIONSHIP TO EMPLOYEE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature (yours and your covered spouse's, if applicable) _____

Date _____

Return one copy of this completed and signed form to: [Name, Title, Company Name, Address].

All premium payments should be made out to [Company Name] and sent to: [Name, Title, Address].

If you have any questions regarding your health care coverage, please call [Name], at [telephone number].

Note: If you expect to be covered under another employer plan, you should verify the actual date that the new coverage will be effective for you and each member of your family, including any exclusions for preexisting medical conditions. If your move to a new employer plan would result in a period of uninsurance of more than 63 days, you should consider continuing your existing coverage through COBRA until your new coverage is effective.

When your COBRA coverage ends, you will receive certification of the duration of your COBRA coverage.