



*Notice of Right to Continue Group Health Coverage for Mini-COBRA Form
(Front)*

Notice of Right to Continue Group Health Coverage for Mini-COBRA

Dear _____:

It has come to our attention that you will no longer be eligible for coverage under your group health plan because of the situation checked off below. State law gives you (and your spouse and/or dependents if they were covered under your plan) the right to continue coverage under your present group health plan at your own expense if you wish. The length of time you may continue coverage is shown under each situation listed below.

Death of an employee

The surviving spouse and/or any dependent children may continue group coverage for up to 36 months.

The employee becomes ineligible for group health coverage after termination of employment or reduction of work hours.

All family members covered under the employee's health plan may continue group health coverage for up to 18 months. Note: If you are qualified for Medicare disability at the time you lose coverage or within 60 days of your loss of coverage, you must notify us 60 days before the end of the 18-month period to continue coverage for an additional 11 months. The premium for the additional 11 months may be up to 150 percent of the premium for active employees.

Divorce or legal separation

The spouse and/or any covered dependent children may continue group health coverage for up to 36 months.

The employee becomes entitled to Medicare coverage.

The spouse, if not also enrolled in Medicare, and/or any dependent children may continue group coverage for up to 36 months.

A child ceases to be a dependent under the employee's family membership.

The child may continue group coverage for up to 36 months.

A retiree substantially loses coverage within one year before or after we file for bankruptcy.

The retiree, spouse, and/or dependents may continue coverage until the death of the retiree, or up to 36 months after the death of the retiree for the qualified surviving spouse and dependents.

Although you are allowed by law to continue group health coverage at your own expense under the above circumstances, continued coverage will be terminated if:

- We cease to maintain a group health plan/or,
- You fail to pay the premium on time/or,
- You are covered by another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition/ or,
- You are entitled to Medicare benefits.

Under the law, you have 60 days to decide whether to stay in your present group health plan. (The deadline for your decision is shown on the Date Continuation Option Expires line on the reverse side of this form.)



*Notice of Right to Continue Group Health Coverage for Mini-COBRA Form
(Back)*

If you (or your spouse and/or dependents) wish to continue coverage under the group plan:

Sign the Beneficiary Election Form.
Check the **Yes** box.

If you (or your spouse and/or dependents) do not wish to continue group health coverage:

Sign the Beneficiary Election Form.
Check the **No** box.
Indicate the reason(s) you do not wish to continue coverage.

If you decide to continue coverage, your first payment will be due within 45 days of the date we receive your Beneficiary Election Form. This bill will cover the time period from the date continued coverage begins (shown below on the Effective Date of Continued Coverage line) through the month we receive your Beneficiary Election Form. (Please note, therefore, that your first payment will be smaller if you make your decision within 30 days.)

Once you have made the first payment for continued coverage, you will be billed monthly at up to 102 percent of the group rates. (The additional two percent is allowed by law to cover the extra administrative expenses that are involved in keeping you in the group. In certain circumstances under state law, your payment may be lower.) The current monthly group rate is shown below. This amount is subject to change when the group rate changes (usually once a year).

If you choose to continue coverage under the group health plan, you will receive coverage identical to what the Plan provides for similarly situated employees and family members.

For Office Use Only

Beneficiary Name: _____ Monthly Group Rate: _____

Contract Number: _____ Group Number: _____

Date Continuation Option Expires: _____

Effective Date of Continued Coverage: _____



Beneficiary Election Form to Continue Group Coverage

Beneficiary Election Form to Continue Group Coverage

I am aware that coverage under my current health plan can be extended for a certain length of time at my expense.

Check one box:

Yes, I choose to continue in my group level health benefit program.

My spouse and/or dependents were covered under my health benefit program and they also choose to continue coverage.

No, I do not wish to continue in my current health benefit program. [If you choose not to continue group insurance, please check off the applicable reason(s).]

I have other group health insurance coverage.

I have elected to convert to nongroup coverage.

I am moving out of state.

This coverage is too expensive.

Other: _____.

Signature: _____ Date: _____

Current Address: _____

**YOU MUST RETURN THIS FORM BY THE DATE SHOWN
BELOW ON THE "ELIGIBILITY EXPIRES ON" LINE**

Eligibility Expires on: _____

Account Name: _____

Contact Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone Number: _____