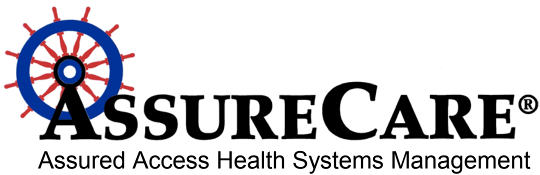

COBRA BENEFITS NOTIFICATION

1) EMPLOYEE NAME (Last, First, Middle)			2) EMPLOYEE SOCIAL SECURITY NUMBER
3) EMPLOYEE ADDRESS	CITY	STATE	ZIP CODE
4) EMPLOYER NAME			5) GROUP #
6) TERMINATION DATE	7) NOTICE DATE		

IMPORTANT

Your group benefits have terminated. If you and/or your dependents are not covered under any other group plan that limits your benefits with respect to a pre-existing condition, you or your dependents may continue the coverage without interruption for up to 18 months.

You have sixty (60) days from the date on this notice to elect to continue coverage. If you elect to continue coverage under the plan your first payment (which would include all monies owed from date of termination to that time) must be made within 45 days of election and monthly thereafter by the due date indicated on your monthly COBRA coupons. Failure to remit payment by the DUE DATE will result in a loss of coverage.

Coverage may be extended from 18 to 36 months if a secondary event occurs. A secondary event is a termination or reduction of hours being followed by:

Death of the employee
Dependent child ceasing to be a dependent
Divorce or legal separation
Medicare entitlement*

Note: To receive this extension, you and/or spouse and dependent child(ren) must notify AssureCare within 60 days of the occurrence of these events.

*There is a special Medicare entitlement rule which states that if a Medicare entitlement occurs (where coverage is not lost) and if followed by a termination or reduction of hours, qualified beneficiaries are entitled to 36 months of COBRA coverage from the date of the Medicare entitlement.

If a qualified beneficiary becomes incapacitated any time during or prior to the election period (60 days), time will “stop” until the person is no longer incapacitated, has a legal guardian appointed, or an executor of the estate is appointed (in the event the qualified beneficiary dies before the date the qualified beneficiary is no longer incapacitated).

Coverage may also be extended from 18 to 29 months in cases where the qualified beneficiary is disabled (according to Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA coverage. [In order for the qualified beneficiary to take advantage of this extension, the Notice of Disability (from the Social Security Administration) must be provided to your previous employer before the expiration of the 18 month COBRA period and within 60 days of the notice.] Second, the 11-month extension is available to *“all qualified beneficiaries”* who lose coverage due to the employee’s termination of employment or reduction of hours, and who elect COBRA coverage, not just the disabled qualified beneficiary.

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If you adopt a child or have a child, you may add that child within 30 days by notifying your employer of the event and completing any necessary forms and pay any increase in the amount of payment due monthly.

If one of the secondary events occurs, please notify your previous employer who will then notify AssureCare.

The continued coverage will cease for any person when:

(1) your former employer no longer provides group health coverage to any of its employees;
(2) the premium for your continuation coverage is not paid;
(3) you become covered under another group health plan *(which does not exclude or limit your benefit with respect to a pre-existing condition)*
(4) you become entitled to Medicare.

If applicable, **please check the coverage you wish to continue** and indicate each member of the family who wishes to continue coverage. Each qualified beneficiary (anyone on the plan at the time that the qualifying event occurred) has independent election rights and has an election period of at least 60 days to elect coverage.

Coverage Information:		**Monthly Rates**	
Effective date:		☐ Single Health:	
Date payments begin:		☐ Family Health:	
		☐ Single Dental:	
		☐ Family Dental	

List dependents to be covered:

Name	Relationship	DOB	Social Security #

If you choose to elect coverage, please return this form to AssureCare at the address listed below, attention COBRA Administrator. If we do not receive notice from you within **sixty (60) days** from the date on this notice we will consider that a refusal of continuation. If you do elect, an 18-month coupon booklet will be mailed to your home. Payments will be due on a monthly basis to maintain covered status.

X______________________________ Signature

______________________________ Date

SS # ______________________________

IF YOU WISH TO CONTINUE YOUR COVERAGE UNDER THIS COBRA PROVISION PLEASE RESPOND BY:

1742 Georgetown Road Suite E
Hudson, Ohio 44236

Phone: (330) 528-3929 Fax: (330) 342-1642

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Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage. To be sure that you, your spouse and your dependent child(ren), if any, receive the necessary information concerning your rights, you should keep the Plan Administrator informed of any address changes. This notice is a summary of your COBRA rights. For answers to specific questions, please contact AssureCare.