Federal COBRA Election Form for Group Health Coverage

COVERED CALIFORNIA

1. Date of notice	2. First date of no coverage	3. Last date to elect continuation

To the Covered Family of:

1. Member identification
2. Group number
3. Group name

4. Current home address (if different) - street address

5. City	6. State	7. ZIP code	8. County

9. Phone number ( ) -	10. Email address

Reason for termination of coverage (COBRA qualifying event). Check one. Date of event

- ☐ Termination of employment (18 months)
- ☐ Reduction of work hours (18 months)
- ☐ Death of covered employee (36 months)
- ☐ Divorce/legal separation from covered employee (36 months)
- ☐ Dependent child no longer eligible (36 months)
- ☐ Covered employee is Medicare covered effective _____ (36 months)

As a participant whose coverage terminated due to a qualifying event, you have the right to elect continuation of your Covered California group health coverage through COBRA. To elect COBRA continuation coverage, complete this Election Form and return it to your former employer. Under federal law, you must have a maximum of 60 days after the date of this notice or from the first date of no coverage, whichever is later, to decide whether you want to elect COBRA continuation coverage under the Plan. You have a maximum 45 days from the date of your election to make your first (1st) payment. **You must pay retroactive to the first day of no coverage above. Benefits will not be reinstated until this form and full payment is received.**

Thereafter, full payments must be received by the first (1st) of each month. You will not receive a monthly statement. Failure to make payment by the first of each month will result in suspension of benefits. Failure to make the required payment within 30 days from the first of each month will result in termination of coverage with no option for reinstatement.

The enclosed notice contains important information about your right to continue your health care coverage administered through Covered California, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. For example, being eligible for COBRA does not limit your eligibility for coverage or for financial assistance through the Covered California Individual Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of loss of coverage.

Please indicate beneficiaries electing continuation through COBRA

Qualified beneficiaries	Birth date	Social Security #	Medical rate per month	Elect medical coverage	Dental rate per month	Elect dental coverage
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N

Note

1. Individuals who become covered under other group health insurance, including Medicare after the qualifying event are no longer eligible for COBRA continuation coverage.
2. Life insurance cannot be continued under COBRA. Contact your life insurance carrier or your former employer.
3. If you participate in a Flexible Spending Account, you may be eligible to continue for the remainder of the current plan year. Contact your former employer.
4. Employee Assistance Program (EAP) may be continued through COBRA. Contact your former employer.

My signature below indicates that I understand the following:

- Payments must be submitted retroactively to the first day of no coverage.
- I am responsible for submitting monthly contributions by the first of each month to avoid suspension of coverage.
- If my payment is not made within 30 days from the first of the month, my coverage will be terminated with no option to reinstate.
- I will not receive monthly billings.
- If I become covered by other group health plan including Medicare after electing COBRA, I am no longer eligible for COBRA continuation.

Signature of applicant	Date

Please return form and COBRA payment to: