COBRA Notice

_____
_____
_____
_____

Date: _____

PQB Name: _____
Spouse Name: _____
Address: _____
City/state/zip: _____

This notice contains important information about your right to continue your health care coverage in the _____ Group Health Plan (the Plan).

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan for you and your covered dependents, if any, as defined on the enclosed Family Member Enrollment Form. If you have any questions concerning the information in this notice or your rights to coverage, you should contact:

_____
_____
_____
_____

If you do not elect to continue your health care coverage by completing the enclosed "Enrollment Form" and returning it to us, your coverage under the Plan will end on _____ due to: _____.

Each of the following qualified beneficiaries is being offered continuation under the Plan:

(List all Beneficiaries):

1. _____ (Last, First, Middle Initial)
2. _____ (Last, First, Middle Initial)

Because of the above event that will end your coverage under the Plan, you are entitled to continue your health care coverage for up to 18 months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on _____ and can last until (18 months).

IMPORTANT – To elect continuation coverage, you MUST complete the enclosed "Enrollment Form" and return it to us. You may mail it to the address shown on the Enrollment Form. The completed Enrollment Form must be post-marked by _____. If you do not submit a completed Enrollment Form by this date, you will lose your right to elect continuation coverage.

Also, since each covered dependents has the equal right to accept or decline the coverage being offered them, if not all members of your family who are eligible for the coverage offered wish to continue coverage, please indicate that as well on the Dependent/Family Member Enrollment Form, if enclosed. Should some but not all of your dependents wish to continue coverage, you are welcome to call the telephone number shown to obtain information about specific premium amounts due.

The total premiums due each month are shown on the Enrollment Form and on the Premium Computation Form. You should pay the total premium due at the time you send in the Enrollment Form, in order to complete your enrollment and continue your coverage. However, you are allowed to delay the premium payment for up to forty-five days after you have signed, dated and submitted your Enrollment Form. Any claims submitted for expenses incurred following the date of the Qualifying Event may be held in suspense until all premiums which are due have been paid.

Future premiums are due on the first of each month thereafter, and should be mailed on or before the due date. Failure to pay premiums by premium due dates may terminate your participation in the Health Benefits Continuation Plan.

If you have any questions about the coverage, its length or the premiums due, please call _____ at _____ during regular business hours.

Sincerely,

COBRA Notice

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants of beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from _____.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a qualified beneficiary enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant, or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify _____ of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify _____ of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify _____ _____ of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify _____ within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

What if I am eligible for trade adjustment assistance?

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact _____ to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

_____
_____
_____
_____

COBRA Notice

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan sends periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

_____
_____
_____
_____

If information is available about alternative coverage (coverage in lieu of continuation coverage, or individual conversion rights), it will appear here: NONE AVAILABLE

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from:

_____

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

COBRA Notice

HEALTH BENEFITS CONTINUATION PLAN (COBRA) ELECTION FORM

_____

PQB NAME: _____
(First Middle Last)
ADDRESS: _____

_____

TELEPHONE: _____

EMPLOYEE: _____

BRANCH: _____

QUALIFYING EVENT: _____

QUALIFYING EVENT DATE: _____

COBRA EFFECTIVE DATE: _____

LIST ELIGIBLE PERSONS TO BE COVERED: (PREVIOUSLY COVERED ONLY, INCLUDE.YOURSELF)

NAME LAST	FIRST MIDDLE	BIRTH DATE	SEX	SOC. SEC. #
_____		_____	____	_____
_____		_____	____	_____
_____		_____	____	_____
_____		_____	____	_____

Premium Description	Coverage Level	Premium
Plan Desc. HRA MONTHLY	Coverage Level	$ _____
Plan Desc. HRA MONTHLY PREMIUM PER SPOUSE	Coverage Level	$ _____
Plan Desc. HRA MONTHLY PREMIUM PER EACH DEPENDENT	Coverage Level	$ _____
TOTAL MONTHLY PREMIUM – Please complete Premium Amount elected.		$ _____

_____

I HEREBY ELECT TO CONTINUE IN THE HEALTH BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS LISTED ON THIS FORM AND AGREE TO PAY THE PREMIUM AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE I OR A CONTINUED DEPENDENT BECOME COVERED UNDER ANOTHER GROUP HEALTH/DENTAL PLAN, BECOME ENTITLED TO MEDICARE, OR ON THE DATE ON WHICH THE GROUP HEALTH/DENTAL PLAN ENDS. I ALSO UNDERSTAND THAT IF I WAS DISABLED AT THE TIME OF MY QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE AND THAT ANY BREAK IN CONTINUED COVERAGE OF MORE THAN SIXTY-THREE DAYS MAY CAUSE LOSS OF COVERAGE "PORTABILITY". This notice also discusses other health coverage alternatives that may be available to you through the Health Insurance Marketplace. There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you would be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket cost will be before you make a decision to enroll. For more information about health insurance options through the Health Insurance Marketplace, please visit www.healthcare.gov.

_____ DATE:_____
Signature of PQB Name: First Middle Last

NOTE: In order to be enrolled in the Health Benefits Continuation Plan this ELECTION FORM must be received no later than _____. Form may be faxed to: _____.

Please make check or money order payable to: _____

Please send completed form to:

_____
_____
_____
_____

COBRA Notice

WAIVER LETTER

_____
_____
_____
_____

RE: Waiver of Right to Continue Benefits under COBRA Continuation

Dear Plan Administrator:

I have received the notification of the right to continue certain covered benefits for myself and my covered dependents, if any, and the cost computation form.

At this time, the undersigned Principal Qualified Beneficiary (PQB) waives the right to purchase the continuation coverage. Family coverage, if provided, is also waived by signature of my spouse, if any in the space provided below.

In waiving this coverage, I (we), hereby acknowledge that at the end of the election period _____, my (our), decision will be final and irrevocable. I (we) also understand that any break in continued coverage of more than sixty-three days may cause loss of "portability" of coverage.

Sincerely,

_____
Signature of: (PQB Name - First Middle Last)

_____
Spouse Signature