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Dear ____________:

Your Insurance benefits with ________________ will terminate effective __________.
However, under a federal law known as COBRA, you may continue health and/or dental benefits for yourself and your family for up to 18 months.

Under COBRA, you are responsible for paying your insurance premiums to ________________ by the 1st of each month. You will have to pay the full cost for the coverage you wish to continue (plus an additional 2% allowed by law. This 2% administrative charge is at the discretion of the employer.) The monthly cost for you to continue your benefits under COBRA is outlined on the attached chart.

In order to continue your benefits, you must complete a new enrollment application and return it to us **within 60 days.** Please include your monthly premium check made payable to:

____

Once your paperwork is received, you will be reinstated back to your termination date.
In this way, you are assured continuous coverage.

In addition, you may be affected by recent changes in Federal law if you become enrolled in health coverage that excludes coverage for preexisting medical conditions.

Under the Health Insurance Portability and Accountability Act of 1996(HIPAA), preexisting condition exclusion generally may not be imposed for more than 12 month (18 months for a late enrollee). The 12 month (or 18 month) exclusion period is reduced by your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without preexisting condition exclusion.

If you have any question about your benefits, the COBRA law or the HIPAA, please contact me.

Cordially,

RATE SHEET

Continuation Coverage under __________________________

Employee Name:______________________________ Birth Date:______________________

Eligible Dependents: ___________________________ Birth Date:______________________

___________________________ Birth Date:______________________

___________________________ Birth Date:______________________

Continuation Coverage Starts: ____________

Coverage Termination Date: ____________

Monthly cost for continuing coverage under the ____________________ contract:

(Check One)

_____ Medical, Rx and Dental: _______________

_____ Medical & Rx Only: _______________

_____ Dental Only: _______________

_____ No Coverage: _______________

Signature of Employee: _____________________________________

Signature of Spouse"
(If Applicable) _____________________________________

Date: _________________

Please complete and return this form to :

____

COBRA WAIVER

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____
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Dear _______

Re: Continuation of Benefits

Via my written signature below, I attest to the fact that I was notified by my employer, ______________, that I have the right to continue my group health insurance core coverage per the COBRA Act due to my termination of employment.

I hereby choose NOT to continue these benefits.

____
(Signature)

____
(Print Name)

____
(Date)