

**ELECTION FORM FOR CONTINUATION OF BENEFITS (COBRA)**

**Coverage may be continued under the following conditions:**

- Retirement, termination or layoff\* - up to 18 months. Effective Date \_\_\_\_\_.
- Spouse and/or child(ren) of deceased or divorced employee - up to 36 months.  
Date of death or divorce \_\_\_\_\_.
- Dependent child reaching maximum age for coverage - up to 36 months. Date child attains the age of 19, ceases to be a full-time student or attains the age of 24 \_\_\_\_\_.

**Note:**

- It is the employee's responsibility to notify the Employee Benefits Division when a dependent child ceases to be an eligible dependent or if an employee is divorced.
- Dependent coverage may be discontinued at any time; however, only newly acquired dependents may be added after the group benefits terminate.

\*Individuals on layoff are eligible to maintain coverage for the first 120 calendar days of the layoff by payment of the regular contribution rates in effect prior to layoff. However, in no event will the continuation of coverage exceed a total of 18 months.

**Other Insurance:** Do you or your dependents have other coverage? \_\_\_ No \_\_\_ Yes

If yes, complete the following: Name and address of insurance provider: \_\_\_\_\_

Name(s) of insured: \_\_\_\_\_ Effective date: \_\_\_\_\_

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Rates will be adjusted each January 1. Check appropriate block(s) to indicate coverage(s) to be continued.

**2009 Monthly premium rates are as follows.**

**Present Health**

	<u>PPOBlue</u>
Participant only	<input type="checkbox"/> \$410.20
Two or more individuals	<input type="checkbox"/> \$1078.82

**Dental:**

	<u>Basic</u>
Participant only	<input type="checkbox"/> \$29.06
Two or more individuals	<input type="checkbox"/> \$76.34

**Vision:**

Participant only	<input type="checkbox"/> \$ 4.00
Two or more individuals	<input type="checkbox"/> \$ 12.02

**SEE REVERSE SIDE FOR IMPORTANT INFORMATION AND SIGNATURE REQUIREMENT.**

Coverage is to be continued for:

Effective date of coverage\_\_\_\_\_

- Self
- Spouse
- Child
- Two or more children

Provide following information for those to be insured.

<u>Name</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**READ CAREFULLY!!!**

I elect to continue coverage for myself and/or my eligible dependents (if applicable) under The Pennsylvania State University healthcare plan. I understand that:

1. **MONTHLY BILLS WILL NOT BE PROVIDED.**
2. Premiums are due by the first of each month.
3. **IF PAYMENT IS NOT MADE WITHIN 30 DAYS OF THE DUE DATE, COVERAGE WILL BE CANCELLED AND CANNOT BE REINSTATED. NOTE THAT HEALTHCARE COMPANIES MAY NOT VERIFY COVERAGE DURING THE GRACE PERIOD.**
4. Checks should be made payable to The Pennsylvania State University and sent to:
 

**Employee Benefits Division  
 Penn State University  
 410 James M. Elliott Building  
 University Park, PA 16802  
 (814) 865-1473**
5. Initial premium payments must be included with the application.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Employee

Phone: \_\_\_\_\_

\_\_\_\_\_  
Employee's ID Number

**\*VERY IMPORTANT NOTICE\***

A Federal law, usually called COBRA, requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. (Both you and your spouse should take the time to read this notice carefully.)

If you are an employee of Penn State covered by PPOBlue, or Dental and Vision, you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part.

In the situation of a layoff the individual shall maintain coverage for the first 120 calendar days of the layoff by payment of the regular contributions. At the end of the 120 days the individual has the option to continue coverage for an additional 14 months under the provisions of COBRA. However, in no event will the maximum continuation of coverage of coverage exceed 18 months.

If you are the spouse of an employee covered by PPOBlue, or Dental and Vision, you have the right to choose this continuation coverage for yourself if you lose group health coverage for **any** of the following three reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
3. Divorce or legal separation for your spouse.

In the case of a dependent child of an employee covered by PPOBlue, or Dental and Vision, he or she has the right to continuation coverage if group health coverage is lost for **any** of the following four reasons:

1. The death of a parent;
2. The termination of a parent’s employment (for reasons other than gross misconduct) or reduction in a parent’s hours of employment with Penn State;
3. Parent’s divorce or legal separation;
4. The dependent child ceases to be eligible under the health insurance plan.

Under COBRA, the employee or family member has the responsibility to inform the Employee Benefits Division of a divorce, legal separation, or a child losing dependent status. When the Employee Benefits Division is notified that one of these events has happened, it

will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have **60 days** from the date you would lose coverage because of one of the events described above to inform the Employee Benefits Division that you want continuation coverage. The ELECTION FORM FOR CONTINUATION OF BENEFITS, along with the initial premium payment, **must be received** by the Employee Benefits Division within the above time period.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, Penn State is required to give you coverage, which is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for up to 3 years unless you lost group health coverage because of a termination or reduction in hours. In that case, the required continuation coverage period is up to 18 months.

However, the law also provides that continuation coverage may be cut short for **any** of the following reasons:

1. Penn State no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group health plan, unless that other plan contains an exclusion or limitation with respect to any preexisting condition affecting you or a covered dependent.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you will have to pay the premium for your continuation coverage. COBRA also specifies that, at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under PPOBlue.

If you enroll your newborn or adopted child(ren) within thirty days of birth or placement for adoption, they will be covered immediately without any preexisting condition limitation.

If the qualifying event was as a result of termination of employment or reduction in hours, and you, or a covered dependent, become disabled at any time during the first 60 days of COBRA coverage, you or your dependent may be entitled to an additional eleven months of COBRA coverage. For this purpose, disabled means you, or your covered dependent, are entitled to Social Security disability benefits. Penn State must be notified of the disability within 60 days of the determination and before the end of the original 18 month period.

If you have any questions about COBRA, please contact the Employee Benefits Division. Also, if you have changed marital status, if a dependent ceases to be a “dependent child”, or you or your spouse have changed address, please notify the Employee Benefits Division at (814) 865-1473.

## **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 (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or 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, including special enrollment rights.

### **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 only for up to a total of 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 a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- 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 COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Penn State University, Employee Benefits Division, 410 James M. Elliott Building, University Park, PA 16802 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 determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one

of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that 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 may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

### **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

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 preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect 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 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.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

## **When and how must payment for COBRA continuation coverage be made?**

### *First payment for continuation coverage*

If you elect continuation coverage, you must make your first payment for continuation coverage not later than 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. You are responsible for making sure that the amount of your first payment is correct. You may contact Teresa Grove, Penn State University, Employee Benefits Division at 814-865-1473 to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

### *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. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of each month for that coverage period. 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 will not send 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 the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. 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 coverage period, 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:

Penn State University  
Employee Benefits Division  
410 James M. Elliott Building  
University Park, PA 16802

### **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.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact Penn State University, Employee Benefits Division, 410 James M. Elliott Building, University Park, PA 16802, 814-865-1473.



## Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.\*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

### ◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at [www.irs.gov](http://www.irs.gov).

For general information regarding your plan’s COBRA coverage you can contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact [*enter name of party responsible for ARRA Premium Reduction administration for the Plan, with telephone number and address*].

If you are denied treatment as an “Assistance Eligible Individual” you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

[www.dol.gov/COBRA](http://www.dol.gov/COBRA) or call 1-866-444-EBSA (3272)

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\* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form and return it to us along with your Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: Penn State University, Employee Benefits Division, 410 James M. Elliott Building, University Park, PA 16802.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

Penn State PPOBlue

**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

Highmark Blue Shield  
100 Senate Avenue  
Camp Hill, PA 17011

**PERSONAL INFORMATION**

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.\*

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*If you checked NO for statement 3, you may still be eligible. See below for more information.

**\*ADDITIONAL ELECTION PERIOD\***

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form which you **MUST** complete and return. If you believe you should have received this additional notice but have not, contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Type or print name \_\_\_\_\_

Relationship to employee \_\_\_\_\_

**FOR EMPLOYER OR PLAN USE ONLY**

This application is:  Approved  Denied  Approved for some/denied for others (explain in #4 below)  
Specify reason below and then return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

\*If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

\_\_\_\_\_

Date \_\_\_\_\_

Type or print name \_\_\_\_\_

Telephone number \_\_\_\_\_

E-mail address \_\_\_\_\_

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

a. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or print name \_\_\_\_\_ Relationship to employee \_\_\_\_\_

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

b. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or print name \_\_\_\_\_ Relationship to employee \_\_\_\_\_

Name                      Date of Birth                      Relationship to Employee                      SSN (or other identifier)

c. \_\_\_\_\_

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Type or print name \_\_\_\_\_ Relationship to employee \_\_\_\_\_

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Plan Name	<b>Participant Notification</b>	Plan Mailing Address
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**PERSONAL INFORMATION**

Name and mailing address	Telephone number
	E-mail address (optional)

**PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one**

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below. Insert date you became eligible _____	<input type="checkbox"/>
I am eligible for Medicare. Insert date you became eligible _____	<input type="checkbox"/>

**IMPORTANT**

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type or print name \_\_\_\_\_

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____	_____
_____	_____