**INITIAL NOTICE OF FUTURE HEALTH INSURANCE**

CONTINUATION COVERAGE RIGHTS  
This notification is being sent to you by the Plan Administrator, {Employer Name}

DATE: {Date of COBRA Letter}

TO: {name of COBRA Qualified Beneficiary EE} and {name of COBRA Qualified

Beneficiary Spouse}and all covered dependents

FROM: {Employer Contact}, {Employer Name}

RE: Enclosed Group Health Plan COBRA Continuation Initial Notification of Rights

You and your dependents are now covered participants under {Employer Name}’s group health dental, vision, health FSA, employee assistance, and/or HRA plan(s) (group health plan). A group health plan includes any medical, dental, vision, health FSA, employee assistance, HRA, or any other plan that provides medical care. For simplicity, any such health plan is referred to in this notice as the “Plan.” This notice generally explains health insurance continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

The enclosed notice does not mean you are losing your group health insurance!

In addition, the notice contains some general information about other health insurance options if you lose your group health insurance with the plan administrator. You may be eligible to buy an individual plan through the Health Insurance Marketplace or enroll in another group health plan through special enrollment procedures. This alternative coverage may or may not be less expensive that health insurance continuation coverage.

Step # 1: Please read the notice carefully. It is important that each individual covered

by the plan read the notice and be familiar with the information. Should you add

additional dependents in the future, notice to the covered employee and spouse at this time

will be deemed notification to that newly covered dependent as well.

Step # 2: If there is a covered dependent whose legal residence is not yours, you are

required to provide in writing to the benefits department the appropriate address

so a separate notice can be sent to them as well. Please use the enclosed COBRA

Address Notification Form for this purpose. If you change your address in the future,

please use the enclosed COBRA Address Notification Form so we can send you future

information as needed.

Step # 3: Understand your COBRA Notification Obligations! Under the terms of the

group health plan, only a spouse and eligible dependents, as defined by the health

insurance policy, can be covered under the plan. Therefore, under the rules of the

policy and COBRA, you or a covered spouse/dependent are required to notify the

plan administrator of a divorce/legal separation or if a covered dependent ceases

to be a dependent under the terms of the group health plan. Please take special

note of the section in the notice that details your notification obligation and the

appropriate steps to take when making this notification. Should you fail to follow

the outlined notification procedures, any available rights under COBRA will be

lost.

Step # 4: Please keep this notice with your personal records for future reference.

Should you have any questions concerning this notice or your notification obligations, please do not hesitate to call {Contact Name}, {Employer Name}, {Employer Address}, {Employer Phone}

Important: Initial Notification Statement of your health insurance continuation coverage rights

TO: **{Name of COBRA Qualified Beneficiary EE},** **{Name of COBRA Qualified Beneficiary Spouse}** and all covered dependents, **{Address of COBRA Qualified Beneficiary}**

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health and/or dental 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 due to certain qualifying events listed below. This notice is intended to inform you, in a summary fashion, of your potential future rights and obligations under the continuation coverage provisions of the law, including what COBRA continuation coverage is, when it may become available to you and your family, and what you need to do to protect the right to receive it. Should an actual qualifying event occur in the future the plan administrator will send you additional information and the appropriate election notice at that time. The premiums you will be required to pay if you chose to continue coverage will be included with the election notice. **Please take special note of your notification obligations, which are highlighted later in this communication.**

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” COBRA applies to each group health plan under the Plan. Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**Qualifying Events for Covered Employee\* -** If you are an employee of **{Employer Name}** covered by **{Employer Name}**’s Group Health Plan you have a right to choose this continuation coverage if you lose your group health plan 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).

**Qualified Events for Covered Spouse\* -** If you are the spouse of an employee covered by **{Employer Name}**’s group health plan, you have the right to choose continuation coverage for yourself if you lose group health plan coverage under **{Employer Name}’s** group health plan for *any* of the following four 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 with **{Employer Name}**;

(3) Divorce or, if applicable, legal separation from your spouse; or

(4) Your spouse becomes entitled to Medicare (Part A, Part B, or both).

Under federal law, the term “spouse” includes a person you are married to (same or opposite sex) and the marriage is recognized by the state in which you reside. In some cases a Plan may allow a "domestic partner" to be covered by the Plan, if they lose health insurance as a result of one of the above listed events, the individual will not be recognized as a COBRA qualified beneficiary, nor will they be subject to COBRA rights and protections, or offered the opportunity to continue health insurance as an individual COBRA qualified beneficiary.

**Qualifying Events for Covered Dependent Children\* -** In the case of a dependent child of an employee covered by **{Employer Name}**’s Group Health Plan, he or she has the right to continuation coverage if group health coverage under **{Employer Name}**’s Group Health and/or Dental Plan is lost for *any* of the following five reasons:

(1) The death of the parent-employee;

1. A termination of the parent-employee’s employment (for reasons other than gross misconduct) or

reduction in the parent-employee’s hours of employment with **{Employer Name}**;

(3) The employee’s (parents) divorce or, if applicable, legal separation;

(4) The parent-employee becomes entitled to Medicare (Part A, Part B, or both); or

1. The dependent child ceases to be a “dependent child” under the terms of **{Employer Name}**

Group Health Plan.

\*Similar rights may apply to certain covered retirees and their covered spouses, and dependent children if **{Employer Name}** commences a bankruptcy proceeding under title 11 of the US code and these individuals lose coverage within one year or one year after the bankruptcy filing.

**Protect your COBRA Continuation Rights!**

**Important Employee, Spouse, and Dependent 60 day Notification Requirement -** Under the group health plan rules and COBRA law, the employee, spouse or a family member has the responsibility to inform **{Employer Name}**’s Group Health Plan Administrator of a divorce, legal separation, or a child losing dependent status under **{Employer Name}**’s Group Health Plan. Notification must be made within **60 days** from whichever date is later: the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event.

🖊N**otification Procedure:** Enclosed please find a “**Qualifying Event Notification Form**” which must be

completed and submitted to Human Resources if one of the events described above occurs. Please make a copy for

your records and mail the form with required documentation attached (ie. Divorce decree) to the address listed on it and document the date you mailed it. Call **{Employer Contact**} within 10 days to insure the form has been received.

If proper notification is not completed within the required 60 day notification period, then rights to continuation coverage will be forfeited. Carefully read the dependent eligibility rules contained in the summary plan description so you are all familiar with when a dependent ceases to be a dependent under the terms of the plan. Failure to remove an individual from the plan beyond the date he/she is eligible to participate may be considered insurance fraud on the part of the employee. **{Employer Name}** has the responsibility to notify its Plan Administrator of the employee’s death, termination, reduction in hours of employment or Medicare entitlement within 30 days of the qualifying event or date coverage ends. Once notified, the plan administrator will then notify you of your continuation coverage rights within 14 days. If the employer is also the plan administrator, then you will receive notice within a maximum period of 44 days from the date of the qualifying event.

**Election Period and Coverage -**When the Plan Administrator is notified that a qualified event has occurred, the Plan Administrator will in turn notify covered individuals (also know as qualified beneficiaries) of their rights to elect continuation coverage within 14 days. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60 day election window is measured from the later of the date the health plan coverage is lost due to the event or from the date of the COBRA notification. If an election is made, coverage will be retroactive to the date it was lost because of the event. This is the maximum period allowed to elect COBRA as the plan does not provide an extension of the election period beyond the required law. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and they cease to be a qualified beneficiary. **NO LATE NOTIFICATIONS WILL BE ACCEPTED!**

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the health insurance, plus a **{Percent charged for admin}** % administration fee. **{Employer Name}** is required to provide you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated non COBRA participants or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

**Length of Continued Coverage – 18 Month Period**

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. Exception: If you are participating in a Medical Flexible Spending Account (FSA) at the time of your qualifying event, you will only be allowed to continue the FSA until the end of the plan year in which your qualifying event occurs. The 18 months coverage period may be extended for the following reasons:

1. **Disability Determination:** If the Social Security Administration determines that you, your spouse or dependent child(ren), if any, were disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of COBRA coverage, the 18 month period may be extended for an additional 11 months to a maximum of 29 months from the date of the Qualifying event for all individuals covered under continuation coverage. If a new born or adopted child is added to a covered employee’s COBRA coverage, then the 60-day disability window for the new born or adopted child is measured from the date of the birth or the date of adoption. It is the qualified beneficiary’s responsibility to obtain the disability determination from the Social Security Administration and provide a copy of the determination to **{Employer Name}** within 60 days of a disability determination and before the end of the original 18 month period. This notification must be done according to the notification procedure shown below. This notice can be made by any of the qualified beneficiaries. If these time frames are not complied with, then the additional 11 month extension of COBRA coverage will not be provided.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, the other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable premium rate may be raised to 150% of the rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the **{enter either 100% or 102% for cost of coverage}** level. It is also the qualified beneficiary’s responsibility to notify **{Employer Name}** within 30 days of when a final determination has been made that they are no longer disabled. **NO LATE NOTIFICATIONS WILL BE ACCEPTED!**

* **Special Medicare Entitlement Rule For Dependents Only** - If you become entitled to Medicare benefits prior to the date of your 18-month qualifying event, then your dependent qualified beneficiaries are eligible for 18 months of continuation coverage, or 36 months measured from the date of the Medicare entitlement, whichever is greater. For example, if you become entitled to Medicare eight (7) months prior to the date on which your employment terminates, your dependent qualified beneficiaries will be offered 29 months of continuation coverage (36 - 7 = 29). You, however, will only be offered 18 months. If this is the case, please contact Human Resources immediately so a correct determination can be made regarding the length of continuation coverage.

1. **Secondary Event - Death of employee, divorce, legal separation, and change in dependent status:** If these events occur during the original 18 (or the above mentioned 29) month period of coverage, the period of coverage for your spouse and dependent child(ren), if any, may be extended for an additional 18 months, resulting in a total of 36 months of coverage from the date of the original qualifying event. Note that to receive this extension, you and/or your spouse and dependent child(ren) must notify the plan administrator in writing within 60 days of the occurrence of these events and within the original 18 month continuation timeline.. This notification must be done according to the notification procedure shown below. In no event, however, will continuation coverage last beyond three years from the date of the original COBRA qualifying event. A reduction in hours followed by a termination of employment is not considered a second event for COBRA purposes. 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.

* **Secondary Event- Medicare entitlement of employee:** If you become entitled to Medicare after your qualifying event, but within 18 months or your qualifying event, your spouse and dependent child(ren), if any, may receive an additional 18 months of coverage. Medicare entitlement can only be a second event if it would have caused you or your dependents to lose coverage under the plan if the first qualifying event had not occurred. This is a rare possibility given that the Medicare Secondary Payer rules prevent most employers for denying coverage to employees who become entitled to Medicare.

🖊N**otification Procedure:** Enclosed please find a “**Qualifying Event Notification Form**” which must be

completed and submitted to Human Resources if one of the events described above occurs. Please indicate that the event is a second event. Please make a copy for your records and mail the form with required documentation attached (ie. Divorce decree) to the address listed on it and document the date you mailed it. Call **{Employer Contact**} within 10 days to ensure the form has been received.

## Length of continuation coverage – 36 Month Period

If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under **{Employer Name}**’s health and/or dental plan, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

**Eligibility**

A qualified beneficiary does not have to show they are insurable to elect continuation coverage, however, they must have been covered by the plan on the day before the event to be eligible for COBRA continuation coverage. If during the 18 months, or 29 months if applicable, of COBRA coverage, a qualified beneficiary acquires new dependents (such as through marriage), the new dependent(s) may be added to the coverage according to the rules of the plan. However, the new dependents do not gain the status of a qualified beneficiary and will lose coverage if the qualified beneficiary who added them to the plan loses coverage.

An exception to this is if a child is born to or placed for adoption with the covered employee qualified beneficiary. If the new born or adopted child is added to the covered employee’s COBRA continuation coverage, then unlike a new spouse, the new born or adopted child will gain the rights of all other “qualified beneficiaries”. The addition of a new born or adopted child does not extend the 18 or 29 month coverage period. This means the COBRA timeline for new born or adopted children is measured from the date of the original qualifying event. Plan procedures for adding new dependents can be found in the Summary Plan Description. Premium rates will be adjusted at that time to the applicable rate.

**{Employer Name}** reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of facts.

## Premium Payment

Under the law, you may have to pay all of the applicable premium plus a **{percent charged for admin}**% administration charge for your continuation coverage. The premium will be adjusted during the continuation period if the applicable premium amount changes. If the coverage period is extended from 18 to 29 months due to disability, **{Employer Name}** may charge up to 150% f the applicable premium during the extended period. Qualified beneficiaries will be allowed to pay on a monthly basis with a grace period of 30 days for payment of the regularly scheduled premium.

**Early Termination of Continuation Coverage**

We may cancel your continuation coverage prior to the expirations of the applicable 18, 29, or 36 month time period if any of the following things occur:

1. If the required premium payment is not paid when due.
2. If a qualified beneficiary first becomes, after the date of election, entitled to Medicare.
3. If **{Employer Name}** terminates its group health plan and ceases to provide coverage to any of its employees.
4. If a qualified beneficiary notifies **{Employer Name}** they wish to cancel continuation coverage.
5. When the qualified beneficiary becomes, after the date of election, covered by another group health plan.
6. If coverage is extended to 29 months due to disability and a determination is made that a qualified beneficiary is no longer disabled. The qualified beneficiary must notify**{Employer Name}** of any final determination that he/she is no longer disabled within 30 days of such determination.
7. For cause, on the same basis that the plan terminates for cause the coverage of similarly situated non COBRA participants.

Should your continuation coverage be terminated for one of the above reasons, a notice will be sent to you at that time informing you of your loss of coverage and outlining any available health coverage options that may be available to you.

## Conversion

At the end of the 18 (29 or 36) months of continuation coverage, a qualified beneficiary must be allowed to enroll in the individual conversion health plan if an individual conversion plan is available at that time. **{Employer Name}** will notify you in writing of this right approximately 30 days prior to the continuation coverage expiration date.

**SPECIAL RIGHT TO ENROLL IN THE HEALTH INSURANCE MARKETPLACE OR WITH ANOTHER EMPLOYER SPONSORED GROUP HEALTH PLAN**

Upon the occurrence of a qualifying event, there will be another health insurance coverage options available for you at that time. First, you will able to buy individual health insurance through the **Health Insurance Marketplace** without a pre-existing condition limitation or exclusion. In the Marketplace, you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll and purchase a plan. In addition, you could be eligible for a new tax credit that lowers your monthly premiums right away.

**60 Day Marketplace Enrollment Period:** You must enroll in an individual plan through the Marketplace within 60 days of the exhaustion of your health insurance continuation coverage as indicated above. A failure on your part to enroll within this 60 day period may result in you having to wait until the next Marketplace open enrollment period and going without health insurance until that time. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or call **1-800-318-2596**.

**30 Day Enrollment In Another Group Health Plan:** Secondly, upon exhaustion of your health insurance continuation coverage, you may qualify for a special enrollment opportunity for another group health plan sponsored by another employer for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees. This special enrollment period also lasts for 30 days from the exhaustion of your continuation coverage. If you are eligible for another employer sponsored group health plan, please contact their benefits department immediately for plan information and procedures for enrollment. One of these options may cost less than health insurance continuation coverage with the plan administrator.

Medicare: In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

* The month after your employment ends; or
* The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Other Coverage Options: You may also be eligible for Medicaid or Children’s Health Insurance Program (CHIP), which, if eligible, may be a coverage option in lieu of COBRA and may cost less than COBRA continuation coverage. You can learn more about these options at: www.healthcare.gov or https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/.

**Notification of Address Change:** To insure all covered individuals receive information properly and efficiently, it is important you notify **{Employer Name}**, in writing, of any change in address immediately. This includes a change in address due to a change in marital status. A “**COBRA Address Notification**” form has been included for your convenience. Please send it to the address at the bottom of this page. Failure on your part to do so will result in delayed COBRA notifications, or a loss of continuation coverage options.

**Questions:** Remember, this notice is simply a summary of your potential future options under COBRA and not a description of your actual group health benefits under the plan. For questions regarding your group health plan benefits, you should refer to your summary plan description, or obtain a copy of the plan document from the Plan Administrator. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of all your actual COBRA rights at that time. If any covered individual does not understand any part of this summary notice, or has questions regarding the information or your obligation, please contact:**{Employer Contact Name} at {Employer Contact Phone Number}.**

**{Employer Contact Name}**

**{Employer Name}**

**{Employer Address**

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 nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s web site at www.dol.gov/ebsa. Should you have any continuation coverage questions regarding the information contained in this or any future notice, you should contact the parties listed above. Keep in mind the information below may change between the time you become covered by the Plan and the time of a qualifying event.

**Insurance Plan Information**

This notice does not provide any information regarding actual health plan benefits. For actual plan coverage information such as deductibles, co-pays, and eligible expenses, contact each individual insurance carrier. Please refer to your insurance card(s) for telephone numbers and plan/group numbers.

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***

### COBRA ADDRESS NOTIFICATION FORM

If you have a dependent that is covered by the group health plan whose legal residence is not yours (dependent child covered by a court order, living with an ex-spouse, etc.), you are required to provide us with the proper address so an initial COBRA notice can be sent to them as well. This does not include a dependent child (whose legal residence is still yours), but is away at school. If you change your address, please use this form to report your new address. Should you have any questions, please call Human Resources immediately. Thank you for your assistance.

**This information must be provided to Human Resources upon commencement of**

**coverage under the group health plan. It may also be used any time to report a change of address.**

**Covered Dependent Address Information**:

|  |
| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

**Covered Dependent Address Information**:

|  |
| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

**Covered Dependent Address Information**:

|  |
| --- |
| Name of covered dependent: |
| Name of guardian, ex-spouse, etc. |
| Street Address: |
| City: State: Zip: |

**Covered Employee Change of Address Section:**

|  |
| --- |
| Name of Employee: |
| Name of dependents this address change applies to: |
| Street Address: |
| City: State: Zip: |

#### Qualifying Event Notification Form

*(To notify* ***{Employer Name}*** *of a qualifying event or Social Security Disability)*

**Attention Employee and/or Spouse and Dependent:**

This form is to be completed by a covered employee, spouse or dependent to report certain events to **{Employer Name}** as required under provisions of the federal Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA). Failure to complete and submit this form in a timely manner will result in a loss of health insurance continuation rights that are available under COBRA. Should you have any questions as to this form’s purpose or how to complete the form, please contact **{Employer Name}**

##### Instructions

Please complete the information requested and submit this form to **{Employer Name}.** The notice must be received by the Plan Administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date that the qualified beneficiary would lose coverage on account of the qualifying event.

|  |
| --- |
| Name of Company: **{Employer Name}** |
| Name of Covered Employee: |
| Name of Reportee: |
| Relationship to Employee: |

**Please Check One:**

**Death- as second event Date of event:\_\_\_\_\_\_\_\_\_\_** (attached copy of death certificate)

**Divorce: Is it a second event? Yes /No Date of event:\_\_\_\_\_\_\_\_\_\_** (attached signed copy of

divorce decree)

**Legal Separation: Is it a second event? Yes/No Date of event:\_\_\_\_\_\_\_\_\_\_\_\_** (attached signed

copy legal separation)

**Child Ceasing to be a dependent: Is it a second event? Yes/No Date of event:\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Disability Date of Social Security disability:\_\_\_\_\_\_\_\_\_\_**

(enclose Social Security Disability determination which needs to be submitted within 60 days from

the date the determination is made and within the original 18 months or continuation coverage)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

signature of reportee Date

**Current Mailing Address of Qualified Beneficiary:**

**Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mail or hand deliver completed form to {Employer Name}, {Employer address}. Thank you.**

***NOTE: Due to the impact of COVID-19, if you experienced a qualifying event, had a COBRA election or premium payment deadline, or a deadline to notify the plan of a disability determination or other event on or after March 1, 2020, all or a portion of deadlines described in this Notice may be extended or disregarded in determining whether the notification or payment is timely until the earlier of (1) 60 days after the announced end of the COVID-19 National Emergency, or (2) 1 year from the applicable deadline.***