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Re: Massachusetts Continuation of Coverage (Mini COBRA) and COBRA

Attached are:

- Mini COBRA and COBRA qualifying events
- Suggested text for notice of right to continue group health coverage

The notice of the right to continue coverage should be sent by **certified mail** to the terminated employee. If the notice and form are hand delivered, please have the terminated employee **sign a delivery receipt. Keep the certified mail notice or delivery receipt in the employee's personnel record.**

The terminated employee's coverage must be canceled within 60 days unless they have already confirmed that they want to continue coverage under the COBRA provisions. If the employee elects COBRA during the allowable period, coverage would be reinstated with a new application retroactive back to the date of termination.

Please call if you have further questions.

Qualifying Events for
Federal COBRA Continuation Coverage and
Massachusetts Mini-COBRA Continuation Coverage

Qualifying Event	**Who is Eligible for Continuation Coverage**	**Standard Coverage Period**
Reduction of hours (may include strike, layoff, regular and medical leave of absence and military duty), or Termination of subscriber's employment (except termination for gross misconduct)	Subscriber and dependents	18 months*
Divorce or legal separation *(The remarriage of a subscriber is not a qualifying event.)*	Dependents	36 months
Subscriber becomes entitled to Medicare	Dependents	36 months
A child reaches the maximum age for group coverage as a dependent or the child is no longer a full-time student	Dependent child	36 months
Death of the subscriber	Dependents	36 months
Bankruptcy proceeding	Retiree Spouse of retiree and dependent child	Lifetime Until the retiree dies, then up to 36 months

* *Coverage may be extended to a maximum of 29 months for the subscriber and dependents if any such Member is determined to be disabled for Social Security disability purposes within 60 days of the qualifying event.*

COMPANY LETTERHEAD

Date:________________

Via CERTIFIED MAIL

Name____________________________

Address__________________________

____

Re: Notice of Right to Continue Group Health Coverage

Dear________________:

Please be advised that you are no longer eligible to be covered under our employee health plans as of_____________. However, you have the option to continue you and your dependents (if covered) benefits under the plan beyond this date.

You have 60 days from the date of this notice, or 60 days from the date your coverage ends, whichever is later, to notify us of your election. If you elect this option, your benefits will be continued until:

- The expiration of __________months following__________.
  (date)
- You become covered under any other group health plan that does not contain any exclusion or limitation for any of your preexisting conditions;
- You or your dependent(s) become entitled to Medicare benefits;
- You fail to pay the monthly charge for this coverage on time; or
- Our employee health plan is no longer in force; whichever event occurs first.

The current monthly charge is $________for an Individual Plan and $_______for a Family Plan. Your first payment will be for the period beginning on____________. This charge includes a 2% administration fee.
(date)

Your first payment must be received within 45 days of the date you sign this election form. Subsequently, you will be billed monthly. Each bill will indicate the amount due, the due date and where to send your payment.

If your first payment is not received on time, you will lose your option to continue coverage. We must receive any subsequent monthly payment with 30 days of the due date; otherwise your coverage will be canceled.

Please complete the bottom portion of both copies of this notice. Keep one copy for your records and return one copy to: ______________________________________

____
(address)

If you have any questions regarding this notice, please contact
______________________________________ @

______________________________________.

I wish to continue my employee benefits under your employee health plan.	Yes	No
I wish to continue my dependent benefits under the above plan.	Yes	No
My first payment is enclosed.	Yes	No
You will receive my first payment within 45 days.	Yes	No

______________________________ ____________________
Signature Date