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COBRA CONTINUATION COVERAGE ELECTION FORM

SECTION 1 – Notification (To be completed by the Designated Employer Representative)

1. Date of Notice: ______________________
2. UHA Benefits Termination Date: ______________________
3. Name: ______________________
4. Employee Name (if different): ______________________
5. Social Security Number: ______________________
6. **IMPORTANT: Employers MUST have 20 or more employees to offer COBRA when an employee's group coverage ends. This form must be completed and returned with the enrollee's first month's premium payment (if electing COBRA coverage) to the Designated Employer Representative at: ______________________ no later than ______________________. If mailed, it must be post-marked no later than this date. Member will NOT be enrolled until payment is received by UHA.**
7. Qualifying COBRA Event: (CHECK ONE BOX BELOW):

EVENT	MAXIMUM LENGTH OF COVERAGE
☐ End of Employment ☐ Retirement ☐ Reduction in hours of employment	Eighteen (18) Months
☐ Divorce/Legal Separation ☐ Death of Employee ☐ Loss of dependent child status ☐ Medicare Enrollment of Spouse/Parent	Thirty-Six (36) Months
☐ Certified Disabled by the Social Security Act (Notice of Award issued by SSA must be attached)	Twenty-Nine (29) Months

8. Date of Qualifying Event: ______________ (Mo/Day/Year)
9. Date COBRA Coverage to Begin: ______________ (Mo/Day/Year)
10. Current Monthly Rates: Single: $ ______________ Two Party: $ ______________ Family: $______________
11. Group Name: ______________________
12. UHA Group / COBRA Division Number: ______________________
13. Designated Employer Representative: ______________________
14. Designated Phone #:______________________

SECTION 2 – Election of COBRA Benefits (To be completed by the Covered Employee and/or Spouse and Dependents) Check one below, sign and return.

☐ **I (We) elect to continue coverage in the UHA Health Plan as indicated below and will be responsible for paying the full cost of the coverage.**

15. List the individuals to be included in the UHA Health Plan continuation coverage:

A. RELATIONSHIP TO EMPLOYEE	B. GENDER (M or F)	C. LAST NAME	FIRST	MIDDLE INITIAL	D. SOCIAL SECURITY #	E. BIRTH DATE (Mo./Day/Yr.)	F. CERTIFIED DISABLED BY SSA (Y or N)
EMPLOYEE							
SPOUSE							
DEPENDENT CHILD							
DEPENDENT CHILD							
DEPENDENT CHILD							

Checks payable to UHA. See attached UHA COBRA Payment Procedures for instructions. Payment is due the first of each month. If payment is not received, coverage will be cancelled. **The monthly COBRA rates are subject to change based on contracted changes with the employer's group plan.**

I hereby certify that above information is accurate and complete. I have read, understand and agree to all the provisions listed under "Election to accept COBRA" on the reverse side of this COBRA Enrollment Form. (SIGN AND RETURN AS STATED IN #6 ABOVE WITH YOUR FIRST MONTH'S PAYMENT).

X______________________ ______________ ______________ ______________
Signature of COBRA Enrollee (or Guardian) Date Phone (Home) Phone (Work/Other)

______________________ ______________________
Print Name and Relationship to individual(s) listed above Mailing Address

☐ **I do not wish to continue my coverage under the UHA Health Plan, for myself and/or my dependents, if any.** (SIGN & RETURN AS STATED IN #6 ABOVE)

X______________________ ______________________ ______________
Signature Print Name and Relationship to individual(s) listed above Date

HOW TO COMPLETE THIS FORM

SECTION 1 – Notification (To be completed by the Designated Employer Representative)

Note: The designated employer representative must inform the Enrollee of their COBRA election rights

1. **Date of Notice:** Date the Qualified Beneficiary is notified of his/her COBRA rights.
2. **UHA Benefits Termination Date:** The Date that the covered employee and/or spouse and dependents will no longer be eligible for coverage under the group's plan for active subscribers (Normally the end of the month following the qualifying event).
3. **Name:** Name of the Qualified Beneficiary who is eligible for COBRA coverage.
4. **Employee Name:** If different from #3, the name of the employee.
5. **Social Security Number:** The 9-digit number under which COBRA benefits are to be paid (For example, the SSN of a child who is currently enrolling under COBRA, who may have been previously covered under a parent's SSN).
6. **Return and completion instructions:** Return address for the Designated Employer Representative and date the COBRA Enrollee must return the UHA COBRA Continuation Coverage Election Form and first month's premium payment (if electing COBRA coverage) to the Designated Employer Representative. The return date should be 60 days from the date of the Qualifying event or 60 days from the Date of Notice, whichever is later.
7. **Qualifying COBRA Event:** Check one. *For covered employees, spouses or dependent children:* Termination of employment for reasons other than "gross misconduct,' Retirement from employment, Reduction in hours of employment or Certified disabled by Social Security Act (SSA). *For spouses or dependent children:* Divorce/Legal Separation of a spouse from a covered employee, Death of a covered employee, Loss of dependent child status or Covered employee's coverage under Medicare.
8. **Date of Qualifying Event:** The Date that the qualifying event occurred.
9. **Date COBRA Coverage to Begin:** The Date that the covered employee and/or spouse and dependents will be eligible to receive COBRA benefits (COBRA regulations do not allow a break in coverage. Coverage must and shall begin immediately following the termination from the group's plan for active subscribers).
10. **Current monthly COBRA Rates:** Current monthly COBRA rates provided by UHA, which represents 102% of the applicable premium. For individuals determined to be disabled (See #7 above) the COBRA rate for the additional 11 months of continued COBRA coverage may be increased to 150% of the applicable premium.
11. **Group Name:** Name of the Group or company.
12. **UHA Group / COBRA Division Number:** UHA group number and applicable COBRA division number.
13. **Designated Employer Representative:** Name of the designated Employer Representative completing the UHA COBRA Continuation Coverage Election Form.
14. **Designated Phone Number:** Phone number of the designated Employer Representative completing the UHA COBRA Continuation Coverage Election Form.

SECTION 2 – Election of COBRA Benefits (To be completed by the Covered Employee and/or Spouse and Dependents)

Election to accept COBRA: Check the election box to accept continuation of coverage. This also indicates that the person checking the box accepts the following:

- Responsibility to pay for the full cost of the coverage
- Coverage will be terminated if payment is not received
- COBRA rate changes based upon contracted changes in benefits and rates of the employer group plan
- Coverage will be cancelled if payment is not received by the first of the month. Coverage will be reinstated retroactively to the beginning of the month once payment is received in full within the current month. (See COBRA Payment Procedures)

15. **Individuals to be enrolled:** Who will be enrolled in COBRA, including their A) Relationship to employee, B) Gender, C) Full Name, D) Social Security Number, E) Birth date, F) Social Security Disability

Signature of COBRA Enrollee: Signature of the person enrolling in COBRA or their legal guardian, including phone number and mailing address.

Election to decline COBRA: Check box if you or your dependents will not be enrolling in COBRA.

Signature: Signature of the person qualified for COBRA to decline coverage or their legal guardian.

COBRA ENROLLEE: Return your completed form along with your first month's premium payment (if you are choosing COBRA coverage) to the Designated Employer Representative at the address listed on #6 above. All payments after the initial payment should be sent directly to UHA (see payment procedure below). DESIGNATED EMPLOYER REPRESENTATIVE: Please submit completed form and initial payment (if applicable) to the address listed on #3 below.

UHA COBRA PAYMENT PROCEDURES

MONTHLY PREMIUM PAYMENT

1. The COBRA Enrollee is responsible to pay for their COBRA coverage. **They will not have eligibility until payment for the current month is received in full. The COBRA monthly billing rates, which represents 102% of the group plan's premium, are subject to change upon the former employer group's contracted renewal.**
2. A COBRA monthly billing statement will be mailed to you after the initial payment is received. UHA's COBRA monthly billing statement is sent as a courtesy reminder of when payment is due. **Payment is due whether or not a billing statement is received.**
3. Payment stub with check made payable to UHA should be sent to: **UHA – COBRA**
700 Bishop Street, Suite 300
Honolulu, HI 96813
4. Payment can also be made by Electronic Funds Transfer (EFT) or Credit card. EFT forms are available on our website, uhahealth.com. Please contact UHA Enrollment Services at (808) 532-4000 ext. 299 for more information regarding credit card payments or any other questions. Notification to terminate your automatic deduction is required by the 25th of the month. Should UHA be notified after this date and payment is deducted, a refund will be processed which may take up to two weeks.
5. **Coverage will be cancelled until full payment for the month is received. UHA does not accept postdated checks or checks for an amount less than the premiums owed.**
6. Coverage will be terminated if an enrollee's check is returned and proper payment is not received by the end of the current month (see #5 above).
7. If coverage is cancelled and payment remains past due beyond the last day of the month due, coverage cannot be reinstated and the account will remain cancelled.

BENEFITS

- Benefits for the COBRA Enrollee will be the same as those offered in the group's plan for active subscribers. If the group's plan has any benefit and/or rate changes, COBRA Enrollees will be affected. The group's plan administrator or Designated Employer Representative should notify COBRA Enrollees of any changes.

CLAIMS

- Claims must be submitted using the COBRA Group/Division number and the COBRA enrollee's member ID number. In most cases, medical offices will prepare all claims on behalf of covered persons.

TERMINATION

- COBRA eligibility will terminate for the following reasons:
  - Coverage as an employee or as a dependent under any group health plan that does not contain any exclusions or limitations for any pre-existing conditions which you, your spouse or dependents may have;
  - Payment is not made on time;
  - The COBRA member meets the maximum length of coverage for their qualifying COBRA event;
  - The group terminates their group plan;
  - Coverage under Medicare (if Medicare becomes effective following COBRA coverage effective date).