COBRA CONTINUATION COVERAGE ELECTION FORM

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage within 60 days after the date of this notice, you may be ineligible for COBRA continuation coverage.

Send completed Election Form to: House Staff Benefits Plan
10-27 46th Ave, Suite 300-2
Long Island City, NY 11101
(Email) benefits@cirbenefitfunds.org
(Fax) (212) 356-8181

This Election Form must be completed and returned by mail, facsimile, or e-mail. If mailed, it must be post-marked no later than 60 days after the date of this notice.

If you don't submit a completed Election Form by the due date described above, you may lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form rather than the date you first became eligible for COBRA continuation coverage.

Read the important information about your rights included in the pages after the Election Form.

COBRA Continuation Coverage Election Form

I (We) elect COBRA continuation coverage in the House Staff Benefits Plan (the Plan) listed below:

Based on your present insurance coverage, you are eligible for the following COBRA Continuation Coverage (Please choose an option below and check the box to indicate that you are making an election):

COBRA OPTION	INDIVIDUAL ☐
Benefits – Rx, Supplemental Major Medical, Obstetrical, Newborn, Hearing Aid, Supplemental Dental, Vision, Mental Health, Urinalysis Monitoring, Hospitals Detox & Rehab and **DentalGuard Preferred (DGP)**	$81.88

You should be aware that the price of COBRA Continuation Coverage is likely to change annually.

	Name	Date of Birth	Social Security Number
a.			
b.			
c.			

Signature _____ Date _____

Print Name _____

Print Address

Address 1 _____

Address 2 _____

City, State, Zip Code _____

Telephone number _____

Important Information About Payment

First payment for COBRA continuation coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, if you do not submit payment in full for the first month of coverage at the time of election of coverage, your coverage will not be continued until payment is received and will terminate as scheduled. You will have 45 days from the date that you elect coverage (the date the Election Form is submitted or if mailed, postmarked) to submit the payment in full for the first month of coverage. When payment in full is received or postmarked within 45 days from the date of election, coverage will be reinstated retroactively to the date that your coverage was terminated or is scheduled to terminate. If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all COBRA continuation coverage rights under the Plan.[1] You're responsible for making sure that the amount of your first payment is correct. You may contact the Benefits Plan Office at benefits@cirbenefitfunds.org or (212) 356-8180 to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for COBRA continuation coverage, you'll have to make periodic payments for each coverage period that follows. 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 COBRA continuation coverage is due on or before the first of the 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'll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You'll get COBRA continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. 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 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.

[1] Due to the COVID-19 National Emergency, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service issued guidance extending timeframes for certain actions related to health coverage under group health plans sponsored by private employers. This guidance may give you more time to make COBRA premium payments. For additional information about this guidance visit: https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to:

House Staff Benefits Plan
10-27 46th Ave, Suite 300-2
Long Island City, NY 11101

All payments must be made by credit or debit card (American Express and Discover are **not** accepted). Please see the Credit Card Authorization Form enclosed.

COBRA CREDIT CARD AUTHORIZATION FORM
HOUSE STAFF BENEFITS PLAN

CREDIT/DEBIT CARD PAYMENT INFORMATION

Complete your payment selection: credit or debit card. American Express and Discover credit cards are not accepted.

First and Last Name: Social Security Number:

Credit/Debit Card Number: Card Expiration Date:

Billing Address (if different from mailing address):
Address_____ City_____ State _____ Zip Code_____

Credit/Debit Card Type: ☐ Visa ☐ Mastercard

If you only need COBRA for a specific time period (e.g. one month or two months), list the date below in which you would like your benefits to end. Your COBRA benefits will terminate on the last day of the month for which a premium is paid.

Billing termination date (optional): _____

Confirm you have read and understood the information below by providing your initials in the box.

☐ I authorize the Plan to charge my credit or debit card for the monthly COBRA Premium in the amount of $_____ per month.

☐ I authorize the Plan to charge my card for the monthly premiums and any other premiums and underpayments that are due.

☐ I authorize the Plan to charge the monthly premiums to my credit or debit card on the 28th day of each month until;

- I cancel my COBRA Continuation Coverage;
- I am no longer eligible for COBRA Continuation Coverage;

☐ I understand that the monthly premium rate for COBRA Continuation Coverage is likely to change annually on July 1st.

☐ I authorize the Plan to adjust the monthly charge to my credit or debit card to reflect any change to the monthly premium rate.

- ☐ I understand to discontinue future charges to my credit or debit card, the Plan must receive written notification within ten (10) business days prior to the 28th of the month for which you intend to cease payment.

- ☐ I understand the Benefits Plan Office will not send me monthly bills.

- ☐ I understand that if a payment is more than 30 days late, I will automatically cease to be covered as of the end of the period for which the last premium payment is remitted.

By submitting this form, I certify all the information I have provided is accurate and complete. I understand that failure to provide complete and accurate information may result in the delay or denial of benefits. I understand the Plan reserves the right to request original receipts or any additional information.

Date_____ **Signature**_____ **Email**_____