«PartFullName» «AndFamily»
«PartAddr1»
«PartAddr2»
«PartAddr3»
«PartCity», «PartState» «PartZip»

«MergedDate»

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

COBRA Election Notice

Dear «Salutation»:

This notice contains important information about your right to continue your health care coverage in the «ClientName» group health plan(s) (the Plan) as well as other health coverage alternatives that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or by calling (800) 318 2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information contained in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice or you may elect online.

«CompanyName» is a third-party administrator contracted by «ClientName» to administer continuation benefits, also known as COBRA. We have been notified that you are eligible to continue your benefits based on the information included in this packet. To elect COBRA continuation coverage, complete the enclosed "Election Form" and submit it to «CompanyName», following the instructions provided or elect online (more information provided below).

Each person ("qualified beneficiary/other eligible") in the category(ies) indicated in the table below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan.

Category	Qualified Beneficiary/Other Eligible
Employee or former employee	«ParticipantFullName»
Spouse, former spouse or other	«SpouseFullName»
Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage or other.	«DependentFullName»
Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan.	«ChildFullName»

If you do not elect COBRA continuation coverage, due to the «EventType» (called your "qualifying event" in this notice) that occurred on «EventDate», your coverage will end on the "Loss of Coverage" date shown in the table on the following page.

If elected, COBRA continuation coverage under the group health component(s) of the Plan specified in the table below will begin on the date shown under "Continuation Eligibility Begins" and can last until the date shown under "Continuation Eligibility Ends."

Benefit	Loss of Coverage	Continuation Eligibility Begins	Continuation Eligibility Ends	Election Form Due
«UniquePlanName1»«UniquePlanName2»«UniquePlanName3»«UniquePlanName4»	«UniqueLossOfCoverDate1»«UniqueLossOfCoverDate2»«UniqueLossOfCoverDate3»«UniqueLossOfCoverDate4»	«UniqueStartDate1»«UniqueStartDate2»«UniqueStartDate3»«UniqueStartDate4»	«UniqueEndDate1»«UniqueEndDate2»«UniqueEndDate3»«UniqueEndDate4»	«UniqueFormDueDate1»«UniqueFormDueDate2»«UniqueFormDueDate3»«UniqueFormDueDate4»

The current monthly cost of your COBRA continuation coverage is shown on the "Election Form." There may be other coverage options for you and your family, including coverage through the Health Insurance Marketplace. Information on other coverage options is available below.

Following this page are the following items:

- **COBRA Continuation Coverage Election Form** – This form must be returned to «CompanyName» no later than the earliest date shown above under "Election Form Due" for the group health components of the Plan you are electing or you must enroll online (more information provided below), or your rights to COBRA continuation benefits will cease.
- **Important Information About Your COBRA Continuation Coverage Rights** – Please read this information carefully.

If you elect to continue your benefit coverage, «CompanyName» will send you coupons to submit with your premium payments. You will be billed from the date continuation eligibility begins. You will be notified if there are any changes to your premiums.

You do not have to send any payment with the "Election Form." It is to your advantage to send the first month's premium payment with your election form so claims can be processed without delay. Your coverage will not be reinstated and carriers will not process claims until both the election form and first payment have been received and processed. Coverage is not reinstated with your carrier the same day «CompanyName» receives your payment. «CompanyName» sends communications to our clients or their insurance carriers to advise them of coverage reinstatement. Please keep in mind that we are a third-party administrator of continuation benefits and do not replace your current insurance carriers. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about your rights to COBRA continuation coverage, you should contact «CompanyName» «CompanyCSRName» by phone at «CompanyCSRPhone», or by e-mail at «CompanyCSREmail». Customer service hours are «CompanyCSRHours».

Thank you.
«CompanyName» «CompanyDepartmentName»

COBRA Election Form Page 1

Date: «MergedDate»
Employer: «ClientName»
Qualifying Event Date: «EventDate»

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to «CompanyName» or enroll online. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: «CompanyName», «CompanyAddress», «CompanyCity», «CompanyState» «CompanyZIP». If a payment is being sent with the Election Form, please return Election Form and payment to «PaymentCompanyName», «PaymentAddress», «PaymentCityStateZIP».

This Election Form must be completed in writing and mailed, e-mailed, faxed, or hand-delivered to «CompanyName». A valid election of COBRA may also be made on our website. See the page titled "COBRA Participant Portal Login" for more information and login instructions. Oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage are not acceptable as COBRA elections and will not preserve COBRA rights:

- **If *mailed*, it must be post-marked no later than the earliest date shown under "Election Form Due" for the group health components of the Plan you want to elect.**
- **If *hand-delivered*, it must be received at the above address no later than the earliest date shown under "Election Form Due" for the group health components of the Plan you want to elect.**
- **If *faxed*, it must be transmitted to «CompanyFAX» no later than the earliest date shown under "Election Form Due" for the group health components of the Plan you want to elect.**
- **If e-mailed, it must be transmitted to «CompanyCSREmail» no later than the earliest date shown under "Election Form Due" for the group health components of the Plan you want to elect.**

If you do not submit a completed Election Form or make an online election by the earliest date shown under "Election Form Due" for the group health components of the Plan you want to elect, you will 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 furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage *may* begin on the date you furnish the completed Election Form (this is contingent on the plan).

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

I (We) elect to continue our coverage in the «ClientName» Group Health Plan(s) (the Plan) as indicated below:

Section 1 – Personal Information

TASC ID# «TASCID»	**Participant ID#** «PartUID»	Date of Birth «PartDateOfBirth»
Name (First, MI, Last) «PartFullName»	**EMAIL ADDRESS:** _____	
Home Address		
City, State, Zip code		Phone Number ( )
Is this an address change? ☐ **Yes** ☐ **No**	Are you eligible for Medicare? ☐ **Yes** ☐ **No** Are you eligible for another group health plan? ☐ **Yes** ☐ **No**	

Section 2 – Spouse and Dependent Information – If your dependents are not shown below, please attach a separate sheet including each one continuing coverage along with the information listed below.

Name (Last, First, MI)	Relationship	Social Security Number	Date of Birth
«SpouseDependentFullName»	«SpouseDependentRelationship»		«SpouseDependentDateOfBirth»

COBRA Election Form Page 2

Section 3 – Benefit Coverage Information

Listed below are the benefits you are eligible to continue.

Benefit	COBRA Start Date	Coverage Level	Monthly Premium
«PPlanName1»«PPlanName2»«PPlanName3»«PPlanName4»«PPlanName5»«PPlanName6»«PPlanName7»«PPlanName8»«PSubsidyPlanName1»«PSubsidyPlanName2»	«PStartDate1»«PStartDate2»«PStartDate3»«PStartDate4»«PStartDate5»«PStartDate6»«PStartDate7»«PStartDate8»«PSubsidyStartDate1»«PSubsidyStartDate2»	«PCoverageLevel1»«PCoverageLevel2»«PCoverageLevel3»«PCoverageLevel4»«PCoverageLevel5»«PCoverageLevel6»«PCoverageLevel7»«PCoverageLevel8»«PSubsidyCoverageLevel1»«PSubsidyCoverageLevel2»	«PLetterPremiumAmt1BeforeDiscount»«PLetterPremiumAmt2BeforeDiscount»«PLetterPremiumAmt3BeforeDiscount»«PLetterPremiumAmt4BeforeDiscount»«PLetterPremiumAmt5BeforeDiscount»«PLetterPremiumAmt6BeforeDiscount»«PLetterPremiumAmt7BeforeDiscount»«PLetterPremiumAmt8BeforeDiscount»«PSubsidyLetterPremiumAmt1»«PSubsidyLetterPremiumAmt2»

Section 4 – Continuation Election Information

Listed below are the benefits you are eligible to continue. Please check to elect or decline each coverage option.

Person	Plan	Elect or Decline
«ParticipantPlansFullName1»«ParticipantPlansFullName2»«ParticipantPlansFullName3»«ParticipantPlansFullName4»«ParticipantPlansFullName5»«ParticipantPlansFullName6»«ParticipantPlansFullName7»«ParticipantPlansFullName8»«ParticipantPlansFullName9»«ParticipantPlansFullName10» «SpousePlansFullName1»«SpousePlansFullName2»«SpousePlansFullName3» «DependentPlansFullName1»«DependentPlansFullName2»«DependentPlansFullName3»«DependentPlansFullName4»«DependentPlansFullName5»«DependentPlansFullName6»	«ParticipantPlansPlanName1»«ParticipantPlansPlanName2»«ParticipantPlansPlanName3»«ParticipantPlansPlanName4»«ParticipantPlansPlanName5»«ParticipantPlansPlanName6»«ParticipantPlansPlanName7»«ParticipantPlansPlanName8»«ParticipantPlansPlanName9»«ParticipantPlansPlanName10» «SpousePlansPlanName1»«SpousePlansPlanName2» «SpousePlansPlanName3» «DependentPlansPlanName1»«DependentPlansPlanName2»«DependentPlansPlanName3»«DependentPlansPlanName4»«DependentPlansPlanName5»«DependentPlansPlanName6»	«ParticipantPlansElectOrDecline1»«ParticipantPlansElectOrDecline2»«ParticipantPlansElectOrDecline3»«ParticipantPlansElectOrDecline4»«ParticipantPlansElectOrDecline5»«ParticipantPlansElectOrDecline6»«ParticipantPlansElectOrDecline7»«ParticipantPlansElectOrDecline8»«ParticipantPlansElectOrDecline9»«ParticipantPlansElectOrDecline10» «SpousePlansElectOrDecline1»«SpousePlansElectOrDecline2»«SpousePlansElectOrDecline3» «DependentPlansElectOrDecline1»«DependentPlansElectOrDecline2»«DependentPlansElectOrDecline3»«DependentPlansElectOrDecline4»«DependentPlansElectOrDecline5»«DependentPlansElectOrDecline6»

Section 5a – Participant Authorization

I have read the accompanying letter and notice of rights. I understand that if I fail to pay any premium payment in a timely manner, continuation benefit coverage will terminate. I agree to notify «CompanyName» if I become covered under another group health care plan that does not contain exclusions or limitations with respect to pre-existing conditions. I also agree to notify «CompanyName» if I become entitled to Medicare.

Signature _____ **Date** _____

Section 5b – Declination Authorization

I have read the accompanying letter and notice of rights. By signing below, I choose to decline all continuation coverage for my dependents and myself.

Signature _____ **Date** _____

Spouse Signature _____ **Date** _____

Important Information About COBRA Continuation Coverage and other Health Coverage Alternatives

What is COBRA 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 through COBRA continuation coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who are not receiving continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including «OpenEnrollment» special enrollment rights.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

To elect COBRA continuation coverage, you must complete the "Election Form" according to the directions provided, and mail, e-mail, fax, or hand-deliver it to «CompanyName» by the earliest date shown under "Election Form Due" for the group health components of the Plan you want to elect. A valid election of COBRA may also be made on our website. See the page titled "COBRA Participant Portal Login" for more information and login instructions. **Failure to do so will result in loss of the right to elect COBRA coverage under the Plan.** Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA continuation 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 the case of a loss of coverage due to end of employment or reduction of hours of employment, coverage generally may be continued only for up to a total of 18 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 (meaning enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement.

In the case of losses of coverage due to an employee's death, divorce or legal separation, 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.

COBRA coverage under a health flexible spending arrangement component of the Plan may last for a shorter period than the COBRA continuation coverage under other group health components of the Plan.

COBRA continuation coverage will be terminated before the end of the maximum period in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

You must notify «CompanyName» in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to (enrolled in) Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage and the maximum period of coverage shown on the Election Form for any group health component benefit is less than 36 months, an extension of the maximum period of coverage for that component benefit may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The period of COBRA continuation coverage under a health flexible spending arrangement cannot be extended under any circumstances. You must notify «CompanyName» of a disability or a second qualifying event in order to extend the period of COBRA continuation coverage. Failure to provide proper notice of a disability or second qualifying event will eliminate the right to extend the period of continuation coverage. For more information about extending the length of COBRA continuation coverage, visit http://www.dol.gov/ebsa/publications/cobraemployee.html. The following sections ("*Disability*" and "*Second Qualifying Event*") describe the circumstances for two types of extension.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration 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 period of COBRA continuation coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them qualifies.

The disability extension is available only if you notify «CompanyName» in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

Please note that in order to be entitled to a disability extension, not only must you provide this notice within 60 days of the latest of the events listed above, but such notice must be provided before the end of the first 18 months of continuation coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify «CompanyName» of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during the disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Plan may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled.

Second Qualifying Event

An extension of coverage may be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA 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, 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.

This extension due to a second qualifying event is available only if you notify «CompanyName» in writing of the second qualifying event within 60 days after the later of

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA 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 COBRA 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 COBRA continuation coverage. The required monthly payment for each group health component of the Plan under which you are entitled to elect COBRA continuation coverage is described on the COBRA Election Form.

Other coverage options may cost less than COBRA continuation coverage. **You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** You can learn more about the Marketplace below.

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

First payment for continuation coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. If you choose to make your election online, you do not need to immediately authorize a payment. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. This is the date your Election Form is:

- post-marked, if mailed to «CompanyName», or
- received by «CompanyName» if hand-delivered or transmitted via e-mail or "fax," or
- the date you make your election online. See the page titled "COBRA Participant Portal Login" for more information and login instructions.

If you do not make your first payment for COBRA continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (Example: John's employment terminates on March 31 and his last day of coverage is March 31. John elects COBRA continuation coverage on May 15. His initial premium payment equals the premiums for April and May and is due on or before June 29, the 45th day after the date of his COBRA continuation coverage election.)

You are responsible for making sure that the amount of your first payment is correct. You may contact «CompanyName» «CompanyCSRName» by phone at «CompanyCSRPhone», or by e-mail at «CompanyCSREmail» to confirm the correct amount of your first payment. Customer service hours are «CompanyCSRHours».

Monthly payments for COBRA continuation coverage

After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of COBRA continuation coverage. The amount due for each month of COBRA coverage for each qualified beneficiary is shown in the Election Form. Under the Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA continuation coverage under the Plan will continue for that month without any break. Neither the Plan nor «CompanyName» will send periodic notices of payments due for these coverage periods. In other words, we will not send a bill to you for your COBRA continuation coverage – it is your responsibility to pay your COBRA continuation coverage premiums on time.

Grace periods for monthly payments

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. «SuspendedClaims1»«SuspendedClaims2»«SuspendedClaims3»

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to continuation coverage under the Plan.

Your first payment and all monthly payments for COBRA continuation coverage should be mailed to:

«PaymentCompanyName»
«PaymentAddress»
«PaymentCityStateZIP»

Another convenient option is to make payments online. **See the page titled "COBRA Participant Portal Login" for more information and login instructions.** If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment if your check or ACH payment is returned due to insufficient funds or otherwise.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in your summary plan description or from «CompanyName». If you have any questions concerning the information in this notice, your rights to coverage, or if you want information on obtaining a copy of your summary plan description, you should contact:

«CompanyName», «CompanyAddress», «CompanyCity», «CompanyState» «CompanyZIP», «CompanyCSRPhone», «CompanyCSREmail»

For more information about rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1 (866) 444 3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep your plan informed of address changes

In order to protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Re: Automatic Withdrawal of Premiums for Continuation Benefits

Dear «PartFirstName»

«CompanyName» is providing administrative recordkeeping services for your continuation benefits through «ClientName». «CompanyName» offers you the option of paying your monthly premiums through automatic withdrawal from a checking or savings account, either through signup with this manual form or through our website. For information on the website option, see the page titled "COBRA Participant Portal Login" for login instructions. With automatic withdrawal, your "initial" withdrawal will be deducted from your account immediately upon receipt and will include the current month and any prior months owing. After that, your ongoing monthly premium payments will be deducted from your account approximately the «ACHDayOfMonth» of each month or the following business day. To take advantage of this convenient payment option, you may complete the enclosed Authorization Form and return it to «CompanyName» or sign up online.

If you have already elected COBRA and choose to change to automatic withdrawal, your account must be paid to current and the first deduction will occur immediately upon receipt. If you are in your 45-day election payment period and your account is not paid to current, any prior months owing will also be deducted at this time.

Please note that your monthly premium is subject to change. You will be notified if there are any changes to your monthly premium, but you will not need to complete a new Authorization Form. Also note that if you are just electing continuation benefits, coverage will not be reinstated with your carriers until first payment is received in our office. Therefore, if you need to be reinstated before the first ACH transaction for your group, you may want to pay your first premium by personal check or money order.

If your account has insufficient funds to complete a scheduled automatic withdrawal, «CompanyName» will request that the premium for that month be paid with a cashier's check or money order.

If you do not choose the automatic withdrawal option, please continue to send your premium payments and coupons to:

«PaymentCompanyName»
«PaymentAddress»
«PaymentCityStateZIP»

If you have any questions regarding the automatic withdrawal process, please contact the «CompanyName» «CompanyCSRName» by phone at «CompanyCSRPhone», or visit our website at «CompanyWebSite». Customer service hours are «CompanyCSRHours».

Thank you.
«CompanyName» «CompanyDepartmentName»

Authorization for Automatic Withdrawal of Premium Payments

Please complete Sections I, II and III below to authorize payment of your continuation benefit premiums through automatic withdrawal. Sign and date the form and return it to «CompanyName». Include a voided check for automatic withdrawal from your checking account or a deposit slip for automatic withdrawal from your savings account. If a voided check or deposit slip is not attached, the automatic withdrawal cannot be honored.

Section I – Participant Information

TASC ID# **«TASCID»**	**Participant ID#** **«PartUID»**	"Initial" withdrawal will be deducted from your account immediately upon receipt of this form.
Participant Name (Last, First, MI) «PartFullName»		Company Name «ClientName»
Participant Home Address		City, State, Zip code

Section II – Financial Institution Information

Name of Financial Institution	Financial Institution Phone Number
Financial Institution Address	
City, State, Zip code	Routing/Transit Number

**Please select the type of account from which you wish to have funds automatically withdrawn and enter the account number and routing or transit number to the right.

☐ **Checking Account Number:** **Routing Number:**	****Remember to include a voided check**
☐ **Savings Account Number:** **Transit Number:**	

Section III – Participant Authorization

I authorize «CompanyName» and the financial institution named above to automatically withdraw the monthly premium payment(s) for my continuation benefits from the checking or savings account listed above. This authority will remain in effect until I notify «CompanyName», in writing, to cancel the automatic withdrawal, or until my continuation benefit coverage is canceled.

Employee Signature: _____ Date: _____

Mail completed form to:
«CompanyName» «CompanyDepartmentName»
«CompanyAddress»
«CompanyCity» «CompanyState» «CompanyZIP»