GUARDIAN® Health Net®

Election of COBRA Continued Coverage

Planholder Name	Group Plan #	Date

Planholder Address

Name of Insured Employee (Last, First, MI)	☐ M ☐ F	Social Security #	Date of Birth	Class

Names of Continuing Eligible Dependents (If more space is needed please attach a separate sheet of paper)

Full Name (Last, First, MI)	Sex	Date of Birth	Relationship to Employee
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Home Address:

Reason for Loss of Coverage *(Check one)*

☐ Termination of Employment ☐ Legal Separation ☐ Child Losing Dependent Status

☐ Reduction of Work Hours ☐ Divorce ☐ Death of Employee

Date Coverage Will Terminate Due to Qualifying Event

For Guardian Use Only

Explanation *(If necessary)*

THIS NOTICE CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHT TO CONTINUE YOUR HEALTH CARE COVERAGE.
Please read the information contained in this notice very carefully.

Federal law permits continuation of Medical, Dental, Vision and stand alone Prescription Drug coverage for certain qualifying events. Each person ("qualified beneficiary") who has one of the qualifying events listed in the chart below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for the period of time listed in the corresponding coverage period. An individual's Life, Accidental Death and Dismemberment and Disability Income insurance may not be continued.

Qualifying Events	Qualified Beneficiary	Coverage Period
Termination (other than gross misconduct)	Employee, Spouse, Dependent Child	18 months
Reduced Hours	Employee, Spouse, Dependent Child	18 months
Employee Enrolled in Medicare	Spouse, Dependent Child	36 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of covered employee	Spouse, Dependent Child	36 months
Loss of "dependent child" status	Dependent Child	36 months

Note:
An individual who is determined to be totally disabled under the Social Security Act at any time during the first 60 days of continued coverage, or a family member of the individual, may extend coverage from 18 to 29 months if the determination is provided before the end of the 18 month period. When it is determined under the Social Security Act that the individual is no longer disabled, continuation beyond 18 months will end in the month that begins more than 30 days after the determination.

COBRA continuation will cost: _____. You do not have to send any payment with this Election Form. Important additional information about payment for COBRA continuation coverage is included in a packet of information, which is included in the pages following this election form.

NOTE: **This is an election form only. It is not intended to constitute complete notice of your COBRA continuation rights. If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact your employer/plan administrator.**

Instructions:

To elect COBRA continuation coverage, complete this Election Form and return it to your employer/plan administrator. 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. This election form must be completed and returned to your employer/plan administrator within 60 days of notification.

If you do not submit a completed Election Form to your employer/plan administrator within 60 days of notification, 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 will begin on the date you furnish the completed Election Form.

PLEASE READ THE CERTIFICATE BOOKLET OR PHS SUBSCRIBER AGREEMENT FOR ADDITIONAL INFORMATION

☐ I do not elect to continue my medical/dental coverage under the Group Plan.

☐ I elect to continue my medical/dental coverage under the Group Plan and agree to the conditions and requirements outlined above. *(Note: In most instances Medicare benefits will be primary for individuals entitled to COBRA.)*

Please continue coverage for:

☐ Employee:	☐ HMO	☐ POS	☐ Indemnity	☐ PPO	☐ Dental
☐ Employee & Eligible Dependents:	☐ HMO	☐ POS	☐ Indemnity	☐ PPO	☐ Dental
☐ Spouse:	☐ HMO	☐ POS	☐ Indemnity	☐ PPO	☐ Dental
☐ Spouse & Child(ren):	☐ HMO	☐ POS	☐ Indemnity	☐ PPO	☐ Dental
☐ Child(ren):	☐ HMO	☐ POS	☐ Indemnity	☐ PPO	☐ Dental

You must advise the planholder, in writing, in the event you are no longer eligible for continuation or you no longer wish to continue coverage.

Signature of Person Electing Continuation	Date

Certified for Planholder By (Name and Title)	Date

KEEP A COPY FOR YOUR RECORDS AND A SEND A COPY TO THE PERSON MAKING THE ELECTION.

IMPORTANT INFORMATION
ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is 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 when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment (if applicable) and/or special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits 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. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer/plan administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of 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 separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), 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. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue 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 considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of 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 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 continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at **www.doleta.gov/tradeact/2002act_index.asp**.

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

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact employer/plan administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown on the Election Form. The periodic payments can be made on a monthly basis.

Grace periods for periodic payments

You will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, 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 under the Plan may 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.

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

Your first payment and all periodic payments for continuation coverage should be sent to your employer/plan administrator.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from your employer/plan administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact your employer/plan administrator.

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 U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should 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.

Name and Address of the party responsible for administration of COBRA benefits:

_____

_____

_____

_____