

**— COBRA NOTICE —
CONTINUATION OF HEALTH BENEFITS COVERAGE
UNDER COBRA FOR INTERMITTENT EMPLOYEES
STATE HEALTH BENEFITS PROGRAM HIGH DEDUCTIBLE HEALTH PLANS**

This page is to be completed by Employer
(Please print or type)

To the Family of —

Notice Date: _____

Employer Name: _____

Emp ID #: _____

SS#: _____

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

If you wish to continue coverage under the provisions of COBRA, you must enroll at this time. Otherwise, you will lose coverage and you cannot enroll later.

Please Note: Instead of enrolling in COBRA continuation coverage, there may be other 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 can learn more about many of these options at www.healthcare.gov.

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer drops out of the SHBP.

In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law. Please refer to Fact Sheet #30, *Continuation of Coverage Under COBRA*, for more information on your election of COBRA coverage.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ, 08625-0299**. If you elect to continue coverage, you will be enrolled retroactive to the date you lost coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The Health Benefits Bureau will send you an invoice of premiums that are due for your coverage (including retroactive premium due).

You should make a copy of this notice and your completed application for your records prior to mailing the application **and** any required proof of dependency documentation to the Division of Pensions and Benefits. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524 or by e-mail at pensions.nj@treas.state.nj.us

COBRA EVENT: (check one)

- Termination: Involuntary
- Termination: Gross Misconduct
- Termination: Voluntary, Other
- Death
- Divorce or Separation/Dissolution of Civil Union or Domestic Partnership
- Dependent Ineligibility Over Age 26

<p>CURRENT COVERAGE TYPE: (check one)</p> <p>Medical Plan: _____ (Indicate Plan Name)</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Member & Spouse/Civil Union Partner</p> <p><input type="checkbox"/> Member & Domestic Partner</p> <p><input type="checkbox"/> Parent & Child(ren)</p> <p><input type="checkbox"/> Family</p>

DATE OF COBRA EVENT: _____

CONTINUATION TERM: _____ months of COBRA eligibility.

LAST DATE OF COVERAGE (Month/Date/Year): Medical _____ Rx _____

EMPLOYER CONTACT AND TELEPHONE #: _____

Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE.

