COBRA NOTIFICATION/ELECTION FORM

Date: _____

RE: NOTICE OF RIGHT TO CONTINUE
GROUP HEALTH INSURANCE COVERAGE

Soc. Sec. Number: _____

FOR DAS-HRE USE ONLY
dep/ee:_____
COBRA exp. date:_____
Start direct bill eff:_____

If you wish to elect coverage through COBRA, you **must:**

- complete and return this COBRA Notification/Election Form.
- complete and return insurance applications with the COBRA form. You may obtain the insurance applications from your agency Human Resources Associate or from the DAS Benefits website at http://benefits.iowa.gov. Separate applications are required for health and dental.

INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR ELECTION OF COVERAGE

Your State group insurance coverage would normally end as of . Federal law, however, permits you to continue coverage, at your expense, for one of the "continuation periods" listed below. NOTE: The term "State group insurance coverage" includes both Medical and Dental insurance coverage. Any person covered at the time of the "event" can elect coverage, including a spouse or dependent, even if the former employee does not elect to continue.

Continuation Period

Coverage may be continued from the date shown above through the earliest of the following:

1. If you qualify for continuation due to termination of your employment or a reduction in your work hours, coverage may be continued for 18 months; 29 months if disabled per the Social Security Administration at any time during the first 60 days of COBRA coverage;
2. If you qualify for continuation for any other reason, coverage may be continued for 36 months;
3. The date you become entitled to Medicare, or you are covered under another group health insurance plan as a result of employment, reemployment, or remarriage;
4. The end of the last month for which the premium is paid on a timely basis;
5. The date the State group insurance plan is terminated.

Individual Purchase

There may be other coverage options for you and your family to buy coverage through the **Health Insurance Marketplace**. In the marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Election and Premium Payment

If you decide to continue either the State group health or dental insurance coverage or both, please complete the reverse side of this form and return it within 60 days after the later of: (a) the date coverage would otherwise end, or (b) the date of this notice.

The State group health and/or dental insurance plan currently in effect for you is listed below along with the monthly premium (subject to change) to continue coverage.

Current Health Insurance Plan & Monthly Premium to Continue	Current Dental Insurance Plan & Monthly Premium to Continue

The insurance company will bill you directly for all monthly premium payments. Please do not send payments to the Department of Administratve Services. Failure to make timely payments will be cause for termination of coverage. Failure to make full payment would be cause for continued coverage to be disallowed. If you wait until close to the end of the 60-day time limit to elect coverage, more than one premium payment may be necessary.

Carefully consider your insurance needs. If you need further assistance contact the Human Resources Associate in the agency where you worked.

You must return this form and insurance application (available from the agency's Human Resources Associate or online at our Web site http://benefits.iowa.gov) to:

Iowa Department of Administrative Services -
Human Resources Enterprise
Group Health and Dental Benefits
Hoover State Office Building
Level A 1305 E. Walnut
Des Moines, Iowa 50319

Qualifying Event: _____
(Termination of Employment, Death of Employee, etc.)

Date of Qualifying Event: _____

TO BE COMPLETED BY THE QUALIFIED PERSON

1. Coverage is to be continued: Yes ☐ No ☐
2. If "yes" is checked, please complete the items below. If "no" is checked, please sign, date, and return this form to the above address.
3. Coverage is to be continued for: Health ☐ Dental ☐

   ☐ Myself only
   ☐ Dependent(s) only
   ☐ Myself and the following dependents

   Names of dependent(s) _____
   _____
   _____
   _____
   _____

4. The subscriber's name to which you are currently a dependent (if applicable):

   _____ Social Security # _____

5. Qualified Person: Birth date (month, day, year) _____

   Social Security Number _____

   Telephone (area and number) _____

_____ _____
(Signature of Qualified Person) *(Date Signed)*

A0254B (04/18)