COBRA Continuation Coverage Election Form

Attention: Isaac Belbel
Five Points Benefit Plans, LLC
6006 North Mesa Street – Suite 108,
El Paso, Taxes 79912

Form completion instructions:

This notice must be sent to the plan participants and beneficiaries by first class mail or hand delivered not later than 14 days after the plan administrator receives notice that a qualifying event occurred.

The individual then has 60 days to decide whether to elect COBRA continuation coverage.

The person has 45 days after electing coverage to pay the initial premium. Premium calculation begins immediately following the qualifying event and will include the following:

- The period of coverage from the date of your qualifying event to the date of your election; and
- Any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period, if any.

COBRA Continuation Coverage Election Form

Date **of Notice**_____

☐ Mailed
☐ Hand delivered

Qualified Beneficiary Information

_____ _____/_____/_____
Name: Last, First, Middle **Social Security Number**

_____ _____ _____ _____
Home Address **Street** **City** **State** **Zip**

Date of Birth: / / **Marital Status:** ☐ **Single** ☐ **Married**

No. of Dependent Children_____ ____

Date of Hire: / / **Policy / ID Number:** _____

Entitlement of COBRA Coverage

As explained in the Notice of Rights accompanying this **form, you** and your spouse and **dependent** child(ren),

if any, may be entitled to continue coverage under the _____and Five Points Benefit Plans', LLC's health plan due to the following qualifying event: _____ which is effective _____.

This qualifying event will result in the loss of health coverage and benefits unless you elect continuation coverage.

If you would like to elect continuation coverage, please read and sign this form and return it to the address below within 60 days of the date of this notice. If this election form is not returned within 60 days of the date of this notice, you will lose your right to elect coverage, and your coverage under the company's group health plan will terminate effective: _____. Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS

YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

Length of COBRA Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period, of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA Coverage Premiums

Within *45* days after the date you elect COBRA coverage, you must pay an initial premium, which includes:

The period of coverage from the date of your qualifying event to the date of your election; and Any regularly scheduled monthly premium that becomes due between your election and the end of the 45-day period, if any.

Once the Plan Administrator receives this election form, you will be notified of the amount of the initial premium you must pay. ***If you fail to pay the initial premium, or any subsequent monthly premium, in a timely fashion, your coverage will terminate.***

Premium payments are generally due within 30 days after the first day of each month of coverage. Premium amounts may change from time to time. You will be notified of any change in the premium amount.

You are eligible for benefit coverage at the same level as in effect immediately before the qualifying event. Unless you expressly elect otherwise, this coverage will not be continued for you (and your spouse and your dependent child(ren), if any). The regular cost of coverage is listed below.

IF PREMIUM PAYMENT IS NOT RECEIVED ON TIME,

COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED.

COBRA Coverage Election Agreement

I have read this form and the notice of my election rights. I understand my rights to elect continuation coverage and would like to take the action indicated below. I understand that if I elect continuation coverage and I fail to pay any premium payment on time, this coverage will terminate. I also agree to notify the Plan Administrator immediately if I or any member of my family become(s) covered under another group health plan or entitled to Medicare after the date of COBRA election.

Please check ONE only.

☐ **I elect to continue the following coverage(s) under the plan.**

☐ Health ☐ Health $_____

List dependents to be covered:

	Name	Date of Birth	Relationship
1.			
2.			
3.			
4.			

☐ I have read this form and the Notice of Rights. I am waiving my right to continuation coverage under the plan.

Signature:_____ **Date:**_____

Name (Please Print):_____

Tel: _____

Address: _____

_____

Send/form to: Plan Administrator, Attention: Isaac Belbel, Five Points Benefit Plans, LLC
6006 North Mesa Street – Suite 108,
El Paso, Taxes 79912

Inquiries should be directed to: Plan Administrator, Office: 915-803- 4198

For Office **Use Only:**

Received by Administrator: _____

#Cobra Coverage 01012019