

## Sample COBRA Letter

### Vermont Companies: When an Employee Leaves

If you have 20 or more employees, your company falls under the federal COBRA guidelines. If you have fewer than 20 employees, your company is subject to Vermont's VIPER guidelines.

### VIPER

For more info on VIPER, go to:

[http://www.bishca.state.vt.us/HcaDiv/consumerpubs\\_healthcare/index\\_consumerpubs.html](http://www.bishca.state.vt.us/HcaDiv/consumerpubs_healthcare/index_consumerpubs.html).

You should also contact the Vermont Division of Health Care Administration for information.

## Sample COBRA Letter

[Date]

[Employee Name]

[Employee Address]

Dear Employee and Covered Dependents:

This notice is intended to summarize your rights and obligations under the group health continuation coverage provision of COBRA. You and your spouse should take the time to read this notice carefully. Should you qualify for COBRA coverage in the future, the group health plan administrator or plan sponsor will send you the appropriate notification.

Federal law requires [Name of Employer] to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

### TO QUALIFY FOR COBRA COVERAGE

**Employees.** As an employee of [Name of Employer] covered by [Group Health Plan Name], you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

**Retirees.** As a retiree, spouse of a retiree, or dependent child of a retiree, of [Name of Employer] covered by [Group Health Plan Name] you have the right to elect this continuation coverage if you lose your group health coverage because [Name of Employer] declares Chapter 11 bankruptcy and you lose your group health care coverage within one year before or after the bankruptcy proceedings.

**Spouses.** As the spouse of an employee covered by [Group Health Plan Name], you have the right to choose continuation coverage for yourself if you lose group health coverage under [Group Health Plan Name] for any of the following reasons:

The death of your spouse who was an employee of [Name of Employer]

A termination of your spouse's employment (for reasons other than gross misconduct)

A reduction in your spouse's hours of employment

Divorce or legal separation from your spouse

Your spouse becomes entitled to Medicare

**Dependent Children.** In the case of a dependent child of an employee covered by [Name of Group Health Plan], he or she has the right to continuation coverage if group health coverage under [Name of Group Health Plan] is lost for any of the following reasons:

The death of a parent who was an employee of [Name of Employer]

The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with [Name of Employer]

Parent's divorce or legal separation

A parent who was an employee of [Name of Employer] becomes entitled to Medicare

The dependent ceases to be a "dependent child" under [Name of Group Health Plan].

## **YOUR NOTICE OBLIGATIONS**

Under the law, the employee or a family member has 60 days from (1) the date of the event or (2) the date on which coverage would be lost, whichever is later, to inform [Name and Address of Plan Administrator] of the employee's divorce or legal separation, or of the employee's child losing dependent status under [Name of Group Health Plan]. Please give notice in the following manner: [specify if you want the person to call you, write to you, etc.]

Failure to give notice within the time limits can result in COBRA coverage being forfeited.

[Name of Employer] has the responsibility to notify [Name of Plan Administrator] of the employee's death, termination of employment, reduction in hours, or Medicare entitlement.

## **TO ELECT COVERAGE**

When [Name of Plan Administrator] is notified that one of these events has happened, [Name of Plan Administrator] will in turn notify the employee, spouse and dependents that they have the right to choose COBRA continuation coverage. The employee and spouse have independent election rights. The employee, spouse and dependents have 60 days from either (1) the date coverage is lost under [Name of Group Health Plan] or (2) the date of the notice, whichever is later, to respond informing [Name of Plan Administrator] that they want to elect continuation coverage. There is no extension of the election period.

If an employee, spouse or dependent does not elect continuation coverage within this election period, then rights to continue group health insurance will end.

If an employee, spouse or dependent chooses continuation coverage and pays the applicable premium, [Name of Employer] is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees or family members. If [Name of Employer] changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

## **DURATION OF COBRA COVERAGE**

**Termination or Reduction in Hours.** If group health coverage was lost because of a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, the continuation coverage period is 18 months from the date of the qualifying event, if elected.

**Employees, Spouses or Dependents with Disabilities.** The 18 months of continuation coverage can be extended to 29 months if the Social Security Administration determines that the employee, spouse or dependent child was disabled on the date of the qualifying event according to Title II (Old Age Survivors and Disability Insurance) or XVI (Supplemental Security Income) of the Social Security Act. Disabilities that occur after the qualifying event do not meet the criteria for the extended COBRA coverage period.

The employee, spouse or dependent must obtain the disability determination from the Social Security Administration and notify [Name of Plan Administrator] of the result within 60 days of the date of disability determination and before the close of the initial 18-month period. The employee, spouse or dependent has 30 days to notify [Name of Plan Administrator] from the date of a final determination that he or she is no longer disabled.

**Multiple Events.** The 18-month continuation period can also be extended, if during the 18 months of continuation coverage, a second event takes place (divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). The 18 months of continuation coverage will be extended to 36 months from the date of the original qualifying event. Upon the occurrence of a second event, it is the employee's, spouse's or dependent's responsibility to notify [Name of Plan Administrator] within 60 days of the event and within the original 18-month COBRA period. COBRA coverage does not last beyond 36 months from the original qualifying event, no matter how many events occur.

## **DURATION OF COBRA COVERAGE**

**Other Qualifying Events.** If group health coverage was lost because of the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under [Name of Group Health Plan], then the continuation coverage period is 36 months from the date of the qualifying event, if elected.

## **COBRA CANCELLATION**

The law provides that continuation coverage may be cut short for any of the following reasons:

[Name of Employer] no longer provides group health coverage to any of its employees

The premium for continuation coverage is not paid in a timely manner

The employee, spouse or dependent becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition

The employee or spouse becomes entitled to Medicare

The employee, spouse or dependent extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that he or she is no longer disabled

The employee, spouse or dependent notifies [Name of Plan Administrator] that they wish to cancel continuation coverage.

## **PREMIUMS**

An employee, spouse or dependent does not have to show that they are insurable in order to choose continuation coverage. But an employee, spouse or dependent must have been actually covered by the group health plan the day before the qualifying event in order to elect COBRA coverage.

An employee, spouse or dependent may have to pay all of the applicable premium, which generally can

not exceed 102% of the plan costs for a 12-month period. An exception exists for coverage of employees with disabilities during the extension from the 19th month to the 29th month. During that time, 150% of the plan cost may be charged. The group health plan may increase the cost that must be paid for COBRA coverage if the applicable premium increases.

The period for paying the initial COBRA premium following the election of coverage is 45 days. The first payment made is to be applied retroactively toward coverage for the period beginning after the date on which coverage would have been lost as a result of the qualifying event.

There is a 30-day grace period following the date regularly scheduled monthly premiums are due. Only in the case of mental incapacity is any further extension permitted, since the group health plan does not permit extensions.

### **CONVERSION PRIVILEGES**

At the end of the continuation coverage period, the employee, spouse or dependent must be allowed the option to enroll in an individual conversion health plan provided under [Name of Group Health Plan] if such conversion plan is available.

### **FURTHER INFORMATION**

If you have any questions about the law or your obligations, please contact [Name of Plan Administrator, Address, and Telephone Number].