

Sample Notice of Coverage Continuation ("Mini-COBRA") Form

INSTRUCTIONS FOR EMPLOYER: This form applies to each "small employer" whose health benefit plan is issued or renewed December 31, 2018. "Small employer" means an employer that employs an average of at least 1 but fewer than 20 "eligible employees" during the preceding calendar year. For the purposes of calculating the average number of eligible employees, "eligible employee" means an employee who is eligible for coverage under the employer's health benefit plan, regardless of whether the employee enrolls in that coverage.

Replace bracketed/italicized prompts with the requested information. Make sure all information is completed and that bracketed prompts are removed from the version you provide to enrollees and qualified dependents. With the properly completed version of this form (or your own form that meets the requirements of A.R.S. § 20-2330), provide the form that an enrollee and qualified dependents would use to enroll in continuation coverage.

[EMPLOYER'S Letterhead]

[*Date of Notice*]

[*Enrollee name, and names of all qualified dependents (if any)*]

[*Current Mailing Address*]

[*City, State and ZIP Code*]

RE: NOTICE OF YOUR RIGHT TO CONTINUE HEALTH PLAN COVERAGE

Dear [*name(s) of the enrollee and all qualified dependents (if any)*]:

Effective [*date after last day of coverage under employer plan*], you will no longer be covered under the [*name of group health plan*] ("**the Plan**") due to the following "**Qualifying Event**" as defined in Arizona Revised Statutes ("**ARS**") § 20-2330(N):

- Your employment was voluntarily (including retirement) or involuntarily terminated for a reason other than gross misconduct.
- Your work hours were reduced below the level required to qualify for health benefits under the employer's health benefits plan.
- You divorced or legally separated from the enrollee.
- The enrollee died.
- The enrollee became eligible for Medicare.
- You no longer qualify as a dependent child under the terms of the Plan.

- You are a retired enrollee or the spouse or dependent child of a retiree that lost coverage within one year before or after the employer from which the enrollee retired filed for Chapter 11 bankruptcy.
- You are in the military reserve or national guard and are called to active duty and your employment is terminated during or after the active duty period.
- The enrollee is in the military reserve or national guard and is called to active duty and during the active duty period the enrollee dies; the enrollee and spouse legally separate or divorce; or a dependent child no longer qualifies as a dependent child.
- The enrollee is in the military reserve or national guard, is called to active duty, and the enrollee’s Continuation Coverage is suspended because the enrollee obtains coverage under the Department of Defense (DoD). Within 63 days after the DoD coverage is terminated, the enrollee may elect to subscribe to Continuation Coverage for the remainder of the applicable time period.

This Notice contains important information about the right of the enrollee (employee) and qualified dependents (including the enrollee’s spouse and dependent children who are covered under an enrollee’s health plan immediately before a qualifying event) to “**Continuation Coverage.**”

It is important that the enrollee and all covered dependents read this Notice. Notification to a covered adult dependent is deemed notification to any covered dependent children living at the same address. In addition, for each covered dependent not living at the address on this Notice, please provide our human resources office the appropriate address so we can send a notice there as well.

You have a right to Continuation Coverage at the full cost of the Plan, which includes the employer’s contribution, the enrollee’s contribution, and an administrative fee that may not exceed five percent (5%) of the total premium. Your full cost of Continuation Coverage is as follows:

[Employer: Below, insert continuation coverage premiums that correspond to the coverages that were in effect at the time of the qualifying event...]

	Monthly Premium
Enrollee	
Spouse	
Dependent Child (each)	
Total	

IMPORTANT! You will lose Continuation Coverage if you fail to pay the premium and administrative fee when due.

If you elect to subscribe to Continuation Coverage, the coverage shall be effective retroactive to the day after your employer group coverage under the Plan ends, and may continue until the earliest of the following:

- Generally 18 months after Continuation Coverage begins. *Under certain circumstances, a qualified dependent who is disabled or an individual who has a second qualifying event may be eligible for a longer Continuation Coverage period. Contact the Plan for further details.*
- You fail to timely pay the premium and administrative fee.
- You become eligible for Medicare or Medicaid, or obtain any other health care coverage. The expiration of Continuation Coverage for this reason only applies to you and not to others who may be covered under Continuation Coverage.
- The employer terminates the Plan for all employees and does not offer a new plan.
- A dependent child no longer qualifies as a dependent child under the terms of the Plan.

If you elect Continuation Coverage, you must do the following:

1. Complete and submit the health benefits enrollment form provided with this Notice within 60 days of the date of this Notice. *[Describe any alternate options for submitting the health benefits enrollment form (such as how to access an online form) to the Plan]*
2. Pay the initial premium within 45 days of the date you elect the Continuation coverage.

Keep your Plan informed of address changes.

In order to protect your family's rights, you should keep the Plan informed of any changes in the address of family members. You should also keep a copy for your records of anything you send to the Plan.

SUBMIT THE COMPLETED HEALTH BENEFITS ENROLLMENT FORM TO:

[Company Name]

[Street Address]

[City, State, ZIP Code]

[Phone: (###)-###-#####]

[Fax: (###)-###-#####]

[Describe any alternate options for submitting the health benefits enrollment form to the Plan]