

## EMPLOYER INSTRUCTIONS FOR COMPLETION OF COBRA NOTICE

- a. To the Family of** — Indicate the employee's full name and current address. Notice must be mailed to meet legal requirements for the notification of dependents, so the address is essential. If the *COBRA Notice* is being sent to a specific dependent, add an attention line with his or her name.
- b. Employee's Social Security Number**
- c. Notice Date** — Date *COBRA Notice* is signed by the Certifying Authority.
- d. Employer Name** — Provide the name of your organization, *e.g.*, Rutgers, Department of Corrections, etc.
- e. Employer Identification Number (EI #)** — Provide the EI # assigned to you by the SHBP
- f. Employee Type** — Indicate if the employee is a 10 or 12-month employee., *i.e.*, they have a contract of employment covering ten or twelve months per year.
- g. COBRA Event** — The event that caused the loss of coverage and entitled the employee and/or dependent(s) to continuation of coverage under COBRA. Choose from the following:
- 1) retirement;
  - 2) privatization;
  - 3) termination other than retirement, *i.e.*, resignation, lay off, firing (other than gross misconduct);
  - 4) reduction in hours;
  - 5) leave of absence;
  - 6) death of employee;
  - 7) divorce, separation, dissolution of civil union or domestic partnership;
  - 8) dependent ineligibility — age 23;
  - 9) dependent ineligibility — marriage, civil union, domestic partnership;
  - 10) dependent ineligibility — moved out of household; or
  - 11) MEDICARE entitlement, *i.e.*, employee selects MEDICARE as primary insurance.
- h. Date of COBRA Event** — Date of the event listed in **g** above. This is not the last date of coverage; it is the date of the event above that will cause coverage to end.
- i. COBRA Continuation Term** — Number of months of eligibility for COBRA coverage. This is generally 18 months for reasons 1 - 5 in **g** above and 36 months for reasons 6 - 11 in **g** above. If the employee has a Social Security Administration approved disability award, he/she is entitled to 29 months of COBRA coverage. A copy of the SSA approval letter must be sent with the *COBRA Application*. Time on leave of absence just before enrollment in COBRA, unless under the federal and/or State Family Leave Act, counts toward the 18-month period and will be subtracted from the 18 months. Time a member spends on federal or State family leave will **not** count as part of the COBRA eligibility period.
- j. Current Coverage** — Mark the type and level of coverage held by the employee at the time of the COBRA event. If an HMO, list the name and number of the HMO. For dental coverage, identify the dental insurance plan.
- k. Last Date of Coverage** — Indicate the last date under the active coverage of the employee for each of the plans listed in **j** above.

**MONTHLY EMPLOYEES (90000):** This date will always be the last day of the month. For COBRA events 1–5, use the SHBP timetable of termination dates in the online *Employer Pensions and Benefits Administration Manual (EPBAM)* at: [www.state.nj.state.us/treasury/pensions/epbam.htm](http://www.state.nj.state.us/treasury/pensions/epbam.htm). For COBRA events 6, 7, 9 and 10, the last date of coverage is the end of the month in which the event occurred. For COBRA event 8, the last date of coverage is December 31 of the year in which the child turned 23. For COBRA event 11, the last date of coverage is the MEDICARE effective date of coverage.

**BIWEEKLY EMPLOYEES (91000):** Use the *Date Schedule Chart* provided by Centralized Payroll to determine termination dates. For COBRA events 1 through 7 and 9 and 10, use the termination date column corresponding to the pay period in which the COBRA event occurred. For COBRA event 8, the last date of coverage is December 31 of the year in which the child turned age 23. For COBRA event 11, the last date of coverage is the MEDICARE effective date of coverage.

- l. Name of Employer Contact and Phone Number** — Name and phone number of individual who should be contacted if there are questions about the *COBRA Notice*.
- m. Signature of Certifying Authority** — Signature of individual authorized to certify that information on the *COBRA Notice* is correct. **No stamped signatures, please.**

Mail to the employee/dependent the *COBRA Notice/Application*, a COBRA rate chart, and a copy of the instructions on the reverse side of this page. Hand delivery to the employee does not meet the legal requirement to notify family members covered under the group coverage. Keep a copy of the *COBRA Notice* for your files.

**CONTACT THE DIVISION OF PENSIONS AND BENEFITS, IF YOU HAVE  
ANY QUESTIONS REGARDING THESE INSTRUCTIONS OR IF YOU  
NEED ADDITIONAL BLANK COBRA NOTICES OR APPLICATIONS.**

# EMPLOYEE / QUALIFIED BENEFICIARY INSTRUCTIONS FOR COMPLETION OF COBRA APPLICATION

Please read the *COBRA Notice* on the opposite side of the *COBRA Application* before you begin to complete the application.

**COBRA APPLICATION — Completed by applicant. Please print or type.**

## SECTION 1 — APPLICANT INFORMATION

This section must be completed by the applicant for the COBRA coverage, that is, the individual who will be the insured person. Provide all requested information and enter only one number or letter per block. For relationship to the employee, enter self, spouse, civil union partner, domestic partner, or child.

## SECTION 2 — CHANGE INFORMATION

This section is to be completed **ONLY** if you are already enrolled for COBRA coverage and are changing that coverage.

## SECTION 3 — EMPLOYEE INFORMATION

This section only has to be completed if the applicant is/was a dependent of the employee. If the employee is the applicant, the section is left blank. **Note:** the employee does not have to continue coverage to allow a dependent to enroll.

## SECTION 4 — COVERAGE ELECTION

**PLEASE READ THE INSTRUCTIONS ON THE ACCOMPANYING RATE CHART AT THIS TIME.** Indicate the coverage that you are electing by marking the appropriate block. You may only select the type of coverage you had as an active employee, e.g., medical, dental, prescription drug, vision. If you had medical coverage you may select any medical plan offered. If you had dental, you may select any dental plan offered — you must enter the name of the dental plan you selected.

You cannot cover dependents under COBRA that you did not cover at the time of the termination of your active benefits. For example, if you had “Member & Spouse/Partner” coverage before termination you may only select “Member & Spouse/Partner” or “Single” coverage at this time, not “Family” or “Parent & Child” coverage. An exception is if the qualifying event increasing your family, e.g. birth, adoption, marriage, civil union was within 60 days of your COBRA election.

## SECTION 5 — HEALTH PROVIDER INFORMATION

Provider participation for medical plan in-network benefits or dental plan organizations (DPO) may be limited in certain geographic areas. Be sure to contact the medical or dental plan to verify network provider participation in your area. You may also search for a participating physician using the Unified Provider Directory which is linked from the SHBP home page: [www.state.nj.us/treasury/pensions/shbp.htm](http://www.state.nj.us/treasury/pensions/shbp.htm). NJ DIRECT out-of-network benefits (or if applicable, NJ PLUS out-of-network or Traditional Plan) and the Employee Dental Expense Plan have no geographic restrictions.

**If you select an HMO**, you must enter your primary care physician’s HMO Identification Number. Contact the HMO or your doctor’s office to obtain the Identification Number and to ensure that your doctor participates in the HMO.

**If you select a DPO**, you must enter the name and address of the participating dentist/dental facility. Contact the DPO to ensure your dentist is participating in their plan.

**Note:** Failure to provide this information will delay enrollment with the insurance carrier.

## SECTION 6 — SPOUSE AND DEPENDENT INFORMATION

If you selected any coverage other than “Single”, you must enter the dependents you want covered on your plan. If your dependent children are adopted, foster or stepchildren, enter the appropriate code in the block on the far right. Otherwise, enter “C”. Federal law requires that a Social Security Number be provided for all covered dependents. If you selected coverage in an HMO, enter each dependent’s primary care physician Identification Number in the appropriate block.

## SECTION 7 — SSA DISABILITY EXTENSION

If you have a disability that has been approved by the Social Security Administration, you may be entitled to an extension of your COBRA coverage for up to 29 months. You must attach a copy of the SSA Award letter approving the disability to obtain this benefit.

## SECTION 8 — CERTIFICATION AND SIGNATURE

The application must be signed by the applicant and dated. The legal guardian may sign in the case of a minor child. Please read the certification carefully because it will have a direct impact on your continuation of coverage.

**UNSIGNED, UNDATED, OR INCOMPLETE APPLICATIONS CANNOT  
BE PROCESSED AND WILL BE RETURNED TO THE APPLICANT.  
ADDITIONALLY, THE COBRA NOTICE PROVIDED TO YOU BY THE  
EMPLOYER MUST BE SUBMITTED WITH THE APPLICATION.**