

EMPLOYER INSTRUCTIONS FOR COMPLETION OF COBRA NOTICE

COBRA NOTICE — Completed by the employer. Please print or type.

- A. To the Family of** — Indicate the employee's full name and current address of record. 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 is signed by the Certifying Authority.
- D. Employer Name** — Provide the name of your organization, e.g., Roselle Township, Totowa Board of Education, Division of Taxation, etc.
- E. Employer ID #** — List your State Health Benefits Group Numbers, e.g., 92-0048-0, 91-000, etc.
- 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.
- 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/privatization, i.e., resignation, lay off, firing;
 4. Reduction in hours;
 5. Leave of absence;
 6. Death of employee;
 7. Divorce, separation, dissolution of civil union or domestic partnership;
 8. Dependent child ineligibility — age 23, through independence (moved out of household), marriage, civil union, or domestic partnership;
 9. Medicare entitlement, i.e., employee seeks Medicare as primary insurance.
- H. Current Coverage Type** — Mark the type and level of coverage held by the employee at the time of the COBRA event. If HMO, list the name and number of the HMO. Only mark the Prescription Drug coverage if your location participates in the SHBP Employee Prescription Drug Plan.
- I. Date of COBRA Event** — Date of the event listed in Section G above. This is not the last date of coverage; it is the date of the event above that will cause coverage to end.
- J. Continuation Term** — Number of months of eligibility for COBRA coverage. This is generally 18 months for reasons 1-5 (listed under Section G above) and 36 months for reasons 6-9. If the employee has a Social Security Administration (SSA) approved disability award, he or she is entitled to up to 29 months of COBRA coverage. A copy of the SSA approval letter must be sent with the *COBRA application*.
- K. Last Date of Coverage** — Indicate the last date of coverage of the employee or dependent for each of the plans listed in Section H above. Please follow the appropriate schedule.
- **Local and State Monthly employers** should follow the SHBP timetable for termination dates, that can be found in the online *Employer Pensions and Benefits Administration Manual* on the Pensions and Benefits Web site: www.state.nj.state.us/treasury/pensions/epbam.htm.
 - **State Biweekly employers** should use the State Centralized Payroll Unit's biweekly payroll chart.
 - The last day of coverage for a **dependent child who turns age 23** is December 31 of the year in which the child turns 23.
 - **For enrollees who elect Medicare** as their primary insurance, the last day of coverage is the Medicare effective date.
- L. Employer Contact and Telephone 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 COBRA SECTION OF THE STATE HEALTH BENEFITS BUREAU,
DIVISION OF PENSIONS AND BENEFITS, IF YOU HAVE ANY QUESTIONS REGARDING
THESE INSTRUCTIONS OR IF YOU NEED ADDITIONAL BLANK COBRA NOTICES, APPLI-
CATIONS, OR INSTRUCTIONS FOR COMPLETION OF THE COBRA APPLICATION**

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 the 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 and entering the monthly premium rate from the chart that accompanied your *COBRA Notice*. You may only select the type of coverage you had as an active employee, e.g., medical and/or prescription drug, and/or dental. If you had medical and/or dental coverage you may select any medical and/or 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 and Spouse/Partner” coverage before termination you may only select “Member and Spouse/Partner” or “Single” coverage at this time, not “Family” or “Parent and 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 NJ DIRECT out-of-network benefits 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, PARTNER, AND DEPENDENT INFORMATION

If you selected any coverage other than “Single”, you must enter the dependents you want covered on your plan and list the appropriate code (natural child, adopted, foster, stepchild, or legal ward). 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. If you selected coverage in a DPO, enter the name and address of each dependent’s dental provider.

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. 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.**