Delaware Mini-COBRA Continuation Coverage Election Notice

(enter date)

(enter name)
(enter mailing address)

Dear **(identify the qualified beneficiary(ies), by name or status)**:

This notice contains important information about your right to continue your health care coverage in the Benefits Connection (enter insurance carrier name) plan. Please read the information contained in this notice very carefully.

To elect continuation coverage, follow the instructions on the next page to complete and submit the enclosed Election and Enrollment forms and return it to us.

If you do not elect continuation coverage, your coverage under the Plan will end on **(enter date)** due to [check appropriate box(es)]:

☐ End of employment
☐ Death of employee
☐ Entitlement to Medicare
☐ Reduction in hours of employment
☐ Divorce or legal separation
☐ Loss of dependent child status

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to nine (9) months or until the Mini-COBRA Law expires [check appropriate box(es)]:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, continuation coverage will begin on **(enter date)**.

Continuation coverage will cost: **(enter amount each qualified beneficiary will be required to pay for each option per month of coverage – not more than 102% of the group rate of the insurance being continued on the due date of each payment) per month.** Payment should be included with the Election and Enrollment forms. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact **(enter name of party responsible for continuation coverage administration, with telephone number and address)**.

Delaware Mini-COBRA Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete both an Election and Enrollment form and return the forms to us. Under Delaware law, you have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage.

Send completed Election and Enrollment Forms to: (enter employer name and address)

These completed forms and payment should be returned by mail (or describe other means of submission and due date). If mailed, it must be post-marked no later than (enter date).

If you do not submit completed forms and payment by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish completed forms and payment before the due date.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage in the Benefits Connection **(enter carrier name & plan)** as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.			
b.			
c.			

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number

Important Information About Delaware Mini-COBRA Continuation Coverage Rights

What is continuation coverage?

Delaware law (18 Del.C. 3571F) now requires small employers (those normally employing 1-19 persons) to offer to employees and their families the opportunity to continue their coverage for up to nine (9) months when there is a "qualifying event" that otherwise would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, employees and dependents eligible to continue coverage may include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage, with no break in coverage, that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who is eligible, and how long will Delaware's Mini-COBRA continuation coverage last?

Employees and eligible dependents who have been continuously insured under the group policy or for similar benefits under any group policy which it replaced, for the three consecutive months ending with the employee's termination by a qualifying event. Coverage may be continued for up to nine (9) months or until the Mini-COBRA Law expires. Continuation coverage is not available if:

(1) the employee or eligible dependent is eligible for coverage under Medicare;
(2) the employee or eligible dependent fails to verify that he is ineligible for employer-based group health insurance as an eligible dependent;

or

(3) the employee or eligible dependent is or could be covered by any other insured or uninsured arrangement that provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to the termination of the employee's group coverage (excluding Medicaid and CHIP – the Children's Health Insurance Program).

If any of these three disqualifying events takes place after continuation coverage has begun, eligibility for coverage ends. The employee or eligible dependent is required within fourteen (14) days of the occurrence of a disqualifying event to provide written notice to the administrator that coverage should terminate.

In addition, continuation coverage will end:

(1) if the employee or eligible dependent fails to make timely payment of a required premium contribution;

or

(2) if the group policy is terminated.

How can you elect continuation coverage?

To elect continuation coverage, each covered employee or eligible dependent must complete the Continuation Coverage Election Form and also an Amerihealth or Highmark BlueCross BlueShield DE Enrollment Form and furnish it according to the directions on the Forms. Unless an eligible dependent's election otherwise specifies, election of continuation coverage by an eligible dependent will be deemed an election of continuation coverage on behalf of any other eligible dependent who would lose coverage by reason of the qualifying event.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal and state law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage; election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Continuation coverage will cost $ **(enter amount each qualified beneficiary will be required to pay for each option per month of coverage – not more than 102% of the group rate of the insurance being continued on the due date of each payment)** per month**.**

When and how must payment for continuation coverage be made?

You may contact **(enter name of employer's staff person responsible)** to confirm the correct amount of your first payment.

Your payment(s) for continuation coverage should be sent to: **(employer name & address)**

For more information

If you have any questions concerning the information in this notice or your rights to coverage, you should contact **(enter name of employer's staff person responsible with telephone number and address).**

Keep Your Administrator Informed of Address Changes

In order to protect your and your family's rights, you should keep **(enter name of employer's staff person responsible)** informed of any changes in your address or contact information. You should also keep a copy, for your records, of any notices you send.