

# MBA / BIAW HEALTH INSURANCE TRUSTS

## Continuation Coverage (COBRA) Election Form

### A. Employee / Employer Information:

Employee Name: \_\_\_\_\_  
*(Please print - last name, first name, middle initial)*

(Former) Employer: \_\_\_\_\_

Employee Date of Birth: \_\_\_\_\_

Employer Group #: \_\_\_\_\_

Employee Social Security #: \_\_\_\_\_

**For Disabled and/or Over age 65 applicants:**

Is applicant "entitled" to Medicare benefits?  Yes  No

If "Yes", indicate date of Medicare Entitlement: \_\_\_\_\_

### B. Qualifying Event / Type of Coverage:

**1. Indicate which QUALIFYING EVENT caused applicant's Loss of Coverage:**

- a.  Termination of employment/reduction in hours
- b.  Death of Employee
- c.  Divorce
- d.  Dependent Child no longer eligible
- e.  Other (explain) \_\_\_\_\_

**4. Indicate type of Continuation Coverage requested: Continue coverage for (check only one box):**

- a.  Employee Only
- b.  Dependent(s) Only
- c.  Employees & Dependents

2. Date of Qualifying Event: \_\_\_\_\_

**Note: Life and AD&D insurance coverages are not included under Continuation Coverage.**

3. Last date of coverage under Employer's plan: \_\_\_\_\_

### C. Applicant Information:

*(Applicant is Employee unless B.4.b "Dependent Only" Continuation Coverage is elected)*

1. Applicant's Name: \_\_\_\_\_  
*(Please print - last name, first name, middle initial)*

2. Social Security #: \_\_\_\_\_

3. Address: \_\_\_\_\_

4. Applicant's Birthdate: \_\_\_\_\_

\_\_\_\_\_  
*(City) (State) (Zip)*

5. Telephone #: \_\_\_\_\_

*(Monthly billing statement and all correspondence will be sent to this address)*

6. List all Dependents for whom Continuation Coverage is elected: *(continue on additional page if necessary)*

Name of Dependent	Date of Birth	Relationship to Employee
_____	_____	_____
_____	_____	_____
_____	_____	_____

### D. Terms and Conditions:

**(Must be signed and dated by Applicant)**

I elect Continuation Coverage on the applicant and dependents (if any) listed above in accordance with the Continuation Coverage terms and conditions listed on the back of this form. I agree to make retroactive rate payment within 45 days of the date of this election for all months outstanding since my employer sponsored coverage ended. I agree to make future rate payments in full within the time frames specified on the back of this form. I have read, understand and agree to the Continuation Coverage provisions set forth on the back of this form:

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Return this Form To: **MBA or BIAW Trust c/o EPK & Associates, Inc.**  
**15375 SE 30th PL. #380; Bellevue, WA 98007**

*Administrator's Use Only*

COBRA No: \_\_\_\_\_ Cov. \_\_\_\_\_

Effective Date: \_\_\_\_\_

# **MBA / BIAW HEALTH INSURANCE TRUSTS**

## **Continuation Coverage (COBRA)**

### **Terms and Conditions for Participation**

1. You are eligible for COBRA Continuation Coverage only if (1) the Employer is a current participant in the MBA or BIAW Health Insurance Trust programs and (2) the Employer has certified it is subject to the Continuation Coverage law. An Employer is subject to the Continuation Coverage law if it employed 20 or more employees on at least 50% of its business days during the previous calendar year. If the Employer is not subject to the Continuation Coverage law, no Continuation Coverage is available to you (or your dependents).
2. To elect Continuation Coverage, you must complete and submit this Continuation Coverage Election Form to the Trust Administrator within 60 days after the day coverage terminated, or, if later the day your Employer gave you this Continuation Coverage Election Form (provided the Employer met their 44 day COBRA notification requirement). If the Employer does not meet the 44 day notification requirement described above, this Election Form must be received, or postmarked, within 104 days from the later of the COBRA qualifying event or the date coverage under the plan terminates. If your Election Form is not received within the 104 day period Continuation Coverage will not be provided through the MBA/BIAW Trust program.
3. You must submit your first Continuation Coverage rate payment within 45 days after the date you elect Continuation Coverage on the Election Form. Your first retroactive rate payment must be for the full amount necessary to cover the initial rate months. The "initial rate months" are the months that end on or before the 45th day after the date of the Continuation Coverage election. After the first rate payment, rate payments are due on the first day of each month for that month's Continuation Coverage, and must be paid in full within 45 days after the first day of the month. If you fail to make full payment within the required time periods, Continuation Coverage terminates retroactively to the last day of the month for which full timely payment has been made, and will not be reinstated.
4. The rate for Continuation Coverage is 102% of the rate charged to similarly situated individuals covered under the Former Employer's group plan. Rates are subject to change at least annually. Rates are also subject to change in the event of a benefit change elected by the Former Employer. COBRA participants are eligible only for the same MBA or BIAW Medical, Dental and Vision benefits selected by the Former Employer.
5. If the employee's spouse or dependent child loses plan coverage because of the employee's death, divorce, or the dependent child loses plan coverage because he or she ceases to be a dependent under the plan, the maximum coverage period (for spouse and dependent child) is three years from the first day of the month following the qualifying event. If the employee, spouse or dependent child loses plan coverage because of a termination or reduction in hours of the employee's employment, the maximum continuation coverage period (for the employee, spouse or dependent child) is 18 months from the first day of the month following the termination or reduction in hours of employment. There are three exceptions:
  - If an employee or family member is disabled at any time during the first 60 days after the termination or reduction in hours of employment, the maximum coverage period for the disabled individual and the family members who elect Continuation Coverage is 29 months from the first day of the month following termination or reduction in hours. The disability that extends the 18 month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the MBA/BIAW Trust Administrator within the 18-month coverage period and within 60 days after the date of the determination. The monthly rate for the 19th and later months of coverage is 150% of the rate charged to similarly situated individuals under the Employer plan.
  - If a second qualifying event that gives rise to a 36 month maximum coverage period occurs (for example, the employee dies, divorces or a child ceases to be an eligible dependent) within the 18-month or 29-month coverage period, the maximum coverage period for the spouse and dependent child becomes three years from the first day of the month following termination or reduction in hours of employment.
  - If the employee becomes entitled to Medicare during the 18-month period that ends on the date of termination or reduction in hours of the employee's employment, the maximum coverage period for the spouse and dependent child ends three years from the date the employee becomes entitled to Medicare.
6. Continuation Coverage automatically terminates (even before the end of the maximum coverage period) when any one of the following 6 events occur:
  - The Former Employer no longer provides a medical, dental or vision plan through the MBA or BIAW Health Insurance Trust (as the case may be) to any of its employees;
  - The full rate payment for Continuation Coverage is not timely paid.
  - You (employee, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition you have. If the other plan has applicable exclusions or limitations, your Continuation Coverage terminates when the preexisting condition exclusion or limitation no longer applies to, or is satisfied by, you;
  - You (employee, spouse or dependent child) become entitled to Medicare benefits (applies only to person entitled to Medicare).
  - If you became entitled to a 29-month maximum coverage period, but then there is a final determination under Title II or Title XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled. However, Continuation Coverage will not end until the month that begins more than 30 days after the determination.
  - An event occurs that permits termination of coverage under the MBA or BIAW Trust for cause.