TASC HRA — COBRA Election Form

Date _____/_____/_____

QUALIFIED BENEFICIARY INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security Number_____ Date of Birth _____

Home Address_____ City _____State_____ Zip_____

Marital status: ❍ Single ❍ Married No. of Dependent Children:_____

Date of Hire:_____ Client Number:_____

Entitlement to COBRA Coverage

As explained in the Notice of Right to Elect COBRA accompanying this form, due to a qualifying event, you, your spouse, and dependent child(ren), if any, could be entitled to continue Health Reimbursement Arrangement (HRA) Plan coverage under the company's health HRA.

This qualifying event will result in the loss of health HRA coverage unless you elect continuation coverage. If you would like to elect continuation coverage, please read, sign, and return this form to your Plan Administrator (i.e. your employer) as soon as possible.

If this election form is not returned within sixty (60) days of the date of this notice, you will lose your right to elect coverage, and your Health HRA coverage under the company's group health HRA plan will terminate.

Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN SIXTY (60) DAYS, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

Length of COBRA Coverage

You, your spouse, and dependent child(ren), if any, are eligible to receive continuation coverage based on Federal COBRA regulations; these regulations vary depending on the type of Qualifying Event that you have experienced.

COBRA Coverage Premiums

Within forty-five (45) days after the date that you elect COBRA Coverage, you must pay an initial premium, which includes:

- The period of coverage from the date of your qualifying event to the date of your election, and
- Any regularly scheduled monthly premium that becomes due between your election and the end of the forty-five (45) day period.

Once the Plan Administrator (i.e. your employer) receives this election form, you will be notified of the amount of the initial HRA premium you must pay. Your coverage will terminate if you fail to pay the HRA initial premium, or any subsequent HRA monthly premium, in a timely fashion.

Generally, the employer's schedule determines when HRA Premium payments are due. You will be notified of any change in HRA premium amount.

You are eligible for health HRA coverage at the same level as was in effect immediately before the qualifying event. Unless you expressly elect otherwise, this coverage will be continued for you (and your spouse and child(ren), if any).

IF HRA PREMIUM PAYMENT IS NOT RECEIVED ON TIME,
COVERAGE WILL TERMINATE AND MAY NOT BE REINSTATED.

COBRA Coverage Election Agreement

I have read this form and the notice of my election rights. I understand my rights to elect continuation coverage and would like to take the action indicated below. I understand that if I elect continuation coverage and I fail to pay any HRA premium payment on time, this coverage will terminate. I also agree to notify the Plan Administrator if I or any member of my family become(s) covered under another group health plan or entitled to Medicare after the date of COBRA election.

Please check ONE only.

❍ I elect to continue health HRA coverage.

List dependents to be covered:

	Relationship	Name	Date of Birth
1)			
2)			
3)			
4)			

❍ I have read this form and the Notice of Right to Elect COBRA. I am waiving my right to continuation coverage under the health HRA.

Signature: _____ Date: _____

Name (Please Print): _____

Address: _____

Telephone: (_____) _____

Complete and return this form to the Plan Administrator (i.e. your employer).