SCMEBF Continuation of Coverage COBRA Application

If you are an eligible member of the Benefit Fund who recently retired or separated from employment, you may continue full-coverage for a limited time, through a federally mandated offering known as COBRA, the Consolidated Omnibus Reconciliation Act. Minimum enrollment is one-month and up to your qualifying limit. Complete this application and return it to the Fund with your first payment.

- If the retired or separated Fund member is NOT electing COBRA coverage and you are currently an eligible dependent of that member, you must fill in the name and Social Security number of the Fund member that you were originally covered under. Domestic Partners may remain as an eligible dependent of Fund retirees **if** your Domestic Partner approval was granted PRIOR to the member's retirement. Domestic Partners **cannot** be added *after* the member retires. If the member predeceases their Domestic Partner, the partner is eligible for 36 months of COBRA.
- For **retired or separated Fund member and their eligible dependents,** COBRA coverage includes full dental, optical, prescription co-payment reimbursement and the hearing aid benefit for the monthly premium of: **$46.76 for each individual** enrolling in single coverage; **$93.52 for two individuals;** or **$126.72 for family coverage** of three (3) or more.
- For **dependents of a retiree who was on the "No-Cost" Basic Retiree Plan**, COBRA coverage includes optical, hearing aid, and retiree dental for a monthly premium of**: $18.20 for single coverage**, **$36.38 for family coverage**.

ELECTION TO CONTINUE COVERAGE

☐ **Continue Coverage:** I understand my request to do so must be received at the address provided within 60-days from the date of this Notice. I also understand I am fully responsible for the premium payment within 45 days of enrollment. If we do not receive the payment PRIOR to the due date, you will have a lapse in coverage and will be personally responsible for any claims processed. Please allow 3-5 business days for your payment to be received and posted to your account.

Payment (Select 1)					
	☐ Credit/Debit	Card #: ______	CVV: ______	Exp: ______	Amt: $______
	☐ Check	Check #: ______			Amt: $______

COBRA ENROLLEE INFORMATION (PLEASE TYPE OR PRINT)

Coverage: (Check 1)	☐ Individual -	Circle One: Member Spouse Child Surviving Spouse	☐ 2 Individuals -	Circle Two: Member Spouse Child Surviving Spouse	☐ Family	ADMIN USE ONLY

COBRA ENROLLEE NAME	ENROLLEE SS #	GENDER	DATE OF BIRTH		ENROLLEE BF#

ORIGINAL FUND MEMBER NAME	ORIGINAL MEMBER SS #	GENDER	DATE OF BIRTH	MEMBER BENEFIT FUND #	START DATE
				BF00	

ADDRESS: NUMBER & STREET OR P.O. BOX	APT. NO.	CITY	STATE	ZIP	THRU DATE

EMAIL ADDRESS	HOME PHONE	CELL PHONE	PLAN	MON

RELATIONSHIP	FIRST NAME M.I. LAST	DATE OF BIRTH	GENDER	SOCIAL SECURITY #

Is anyone applying for continued coverage also covered by another dental, optical, hearing aid or prescription care plan? ☐ Yes ☐ No

If yes, name of carrier ______________ ☐ Dental ☐ Optical ☐ Hearing Aid ☐ Prescription | Coverage: ☐ Individual ☐ Family

QUALIFYING EVENT

EVENT DATE	TYPE OF EVENT	DURATION	
	Employment separation or reduction in work hours	18 months	**BY-LAW, COBRA COVERAGE/PAYMENTS MUST BEGIN THE DAY AFTER YOUR QUALIFING EVENT.** THERE CAN BE NO LAPSE IN COVERAGE. (Example: Last day of employment 1/15; COBRA coverage & payment begins 1/16.) In the event of a death of a member – A survivor may remain on (Full) COBRA when the member predeceases the spouse/dependent, or if the family was on the "No-Cost" Basic Retiree Plan, they may remain on Retiree COBRA, both providing timely payments are made. Survivors may only remain on the plan they are in at the time of death and have NO rights to other benefits offerings. (The Death Certificate must be provided to the Fund.)
	Retirement	18 months	
	Dependent aged out 26 years old	36 months	
	Divorce or legal separation	36 months	
	Marriage of dependent or dependent turns age 26	36 months	
	Death of employee	Indefinite	
	Disability Retirement*	Addt'l 11 months	If designated "Disabled" by SSI, a copy is required.

☐ **I <u>DO</u> qualify for <u>Retiree Benefits</u> in accordance with the Benefit Fund Reference Guide eligibility guidelines. Therefore, I, exercise my right for continous coverage from the date of my separation from employment up through the time frame that I quality for under COBRA. I understand I am only obligated to maintain COBRA coverage monthly and will revert back to the "No-Cost" Basic Retiree Plan upon completion of COBRA or as payments cease. I understand that if I do not elect to continue my benefits under COBRA within 60-days, I will forfeit my COBRA benefits at a later date, and will remain in the "No-Cost" Basic Retiree Plan.**

☐ **I <u>DO NOT</u> qualify for Retiree Benefits in accordance with the Benefit Fund Reference Guide eligibility guidelines. However, I exercise my right to continue coverage under COBRA from the date of my separation from employment and for as long as I maintain the premium payments up through the time frame that I quality for under COBRA. I understand if I do not choose to continue my benefits under COBRA within 60-days, I will forfeit my COBRA benefits.**

I have read and understand the statement of rights and conditions on this documentation. I hereby request continued coverage as indicated above. I understand that failure to make timely payments of required COBRA premiums will result in **<u>permanent</u>** loss of COBRA coverage. I also understand each applicant must have been covered by the Benefit Fund at the time of the qualifying event, except for added family members as stated under "COBRA" in my benefit booklet. I agree to notify the Fund if any of the above persons who obtain other coverage or when changes to their status occurs after this coverage begins. I understand, this form supersedes any and all previous forms that I may have previously submitted.

Make Check Payable to and Return to:
Suffolk County Municipal
Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, NY 11716-2513
(631) 319-4099

______________________________ ______________________________

SIGNATURE **DATE**

<u>Additional Rules and Regulations for COBRA –</u>

- *COBRA begins on the first day of separation or retirement. A member has 60-days to enroll in COBRA and 45-days thereafter to make their first payment. The first payment is retro-active to the first day of separation or retirement. Members cannot "skip" months of coverage even if they choose enrollment months after they qualify. (Example: Last day of employment 1/15; COBRA coverage & payment begins 1/16)*
- *The Fund encourages you to make your first payment when submitting the application to prevent a lapse in coverage.*
- *Retirees who opt-in and pay for COBRA, will revert to the "No-Cost" Basic Retiree Plan once COBRA concludes or they stop COBRA coverage. At any time, they may choose to enroll in one of the "Self-Pay" Enhanced Retiree Plans. The Fund will automatically notify you upon the conclusion of your COBRA coverage and will provide you with options for other coverage, should you qualify.*
- *Eligible Retirees and Vested members may choose Individual COBRA, and all other eligible dependents can remain on the "No-Cost" Basic Retiree Plan. If you are NOT a vested member of the Fund, you CANNOT separate enrollment of your eligible dependents and you must enroll each of them in COBRA coverage or none of them will have continuation of coverage.*
- *You may receive 11- additional months of COBRA if you are deemed retired under a disability, even if this designation comes after retirement begins. A copy of the designating paperwork from Social Security disability must be provided to the Fund.*
- *Should you divorce, your spouse and eligible step-children are eligible for COBRA coverage for up to 36-months if they enroll and pay for COBRA coverage (provided they were dependents under your plan and had an approved Statement of Dependency on file at the Fund). You, as the member of the Fund, are responsible for notifying the Fund within sixty-days (60) of the Qualifying Event (divorce) and MUST supply the Fund with a copy of your divorce decree. If you fail to notify the Fund within the required time frame, coverage will be denied. Should a member's dependent use Fund benefits after they are no longer eligible, the Fund* ***MEMBER is responsible to repay ALL Fund benefits*** *used by their former dependent and may risk losing their own coverage if repayment does not occur. Notify the Fund promptly upon a divorce.*
- *Dependents over the ages of 26 who are no longer eligible under your coverage, are offered COBRA continuation of coverage for a period of up to 36-months upon their qualifying event. Benefits will be offered under their own plan and ID number, not the plan of the original member.*
- *If the member predeceases their spouse or eligible dependent(s) while on COBRA the eligible dependent(s) may remain on COBRA, indefinitely, as long as the monthly premiums are paid. Survivors may not move to another plan or add dependents to this plan and will be dropped from coverage permanently if payment is in default.*