NORTH TONAWANDA CITY SCHOOL DISTRICT

TO: _____

FROM: Laurie Burger

DATE OF NOTICE: _____

RE: Notice of Right to Continue Group Health Benefits-Public Law 99-272 (COBRA)

The group health insurance coverage under which you have been covered ceased on _____ for the reason identified below:

_____1. Termination of Employment or reduction in hours as of:_____.
_____2. The Employee's death on:_____.
_____3. The Employee's divorce or legal separation effective: _____.
_____4. As a dependent child ceasing to be a "dependent" as defined under the medical plan as of _____.
_____5. Loss of dependent coverage when an employee becomes eligible for Medicare benefits on _____.
_____6. Employee request effective: _____.
_____7. Other: _____.

Each individual enrolled for your group health insurance coverage is entitled to elect COBRA continuation coverage.

This form advises you and your dependents of your right to continue group health insurance coverage through the North Tonawanda City School District. It is important that you read and comply with the following:

a. Prior to _____, you must complete and return the enclosed "Statement of Intention" regarding continuation of health insurance coverage. This form should be returned to the Personnel Office, 176 Walck Rd., North Tonawanda, NY 14120. Failure to respond by this date will terminate your right to continued health insurance coverage.

b. Payment in the amount of $_____for individual coverage or $ _____family coverage payable to the North Tonawanda School District Treasurer must be made in accordance with the COBRA requirements (a copy of which is attached). We ask that you make your first payment by _____. This payment covers the period from _____to_____.
Monthly cost for this health coverage is $_____for individual and_____ for family
c. You will receive a bill for all future payments due on a quarterly basis. Payments may be made on a monthly basis payable on the first of each month.

If you respond immediately, you will assure continuity of coverage or reinstatement and avoid possible claim denial if coverage is cancelled while awaiting your decision. Assuming payment is received as required, group health insurance coverage will be continued for:

- 18 months following termination or reduced hours.
- 36 months following the date of an employee's death, divorce, legal separation or loss of coverage due to Medicare eligibility or change in dependent status.
- Until the date on which health coverage is no longer provided by the school district.
- Until the date on which you are covered under another group health plan entitled to Medicare.

STATEMENT OF INTENTION

NORTH TONAWANDA CITY SCHOOL DISTRICT

Continuation of Group Health Insurance

Form Distributed on _____. Election Period Expires on _____. This form must be completed and returned to the Personnel Office, 176 Walck Rd., North Tonawanda, NY 14120 no later than 09/01/2016. If continued coverage is desired, all sections must be completed. If you do not want coverage, sections 1, 2, 3 and 6 must be completed.

Section 1 – General Information (Please Print Clearly)

Name _____ Date of Birth: _____/_____/_____

Address _____ Phone # (____) ____-_____

_____ S.S.# ____-____-____

Section 2 - Sponsor Information

Please provide the name and social security # of the North Tonawanda School District Employee under whom you were previously provided health coverage.

Name _____ S.S.# ____-____-____

Section 3 - Qualifying Event

I am eligible for continuation of health coverage for the following reason:

__X__ 1. Employment termination or work hour reduction.

_____ 2. Death of covered employee

_____ 3. Divorce or legal separation from covered employee

_____ 4. No longer an eligible dependent

Effective date of the event checked above is _____

_____ 5. Other

Section 4

Please designate the health coverage you would like to continue: (check one)

_____ 1. NOVA Group # _____

_____ 2. Community Blue Group _____

__X__ 3. Independent Health Group # **22891-01**

_____ 4. HCP Univera Group _____

_____ 5. Other_____

I would like to continue **individual/family** coverage. (Circle one)

If family coverage is chosen, please complete Section 5.

Section 5 – Dependent Information

Name	Birth Date	Sex	Relationship	Social Security No.
1.				____-____-____
2.				____-____-____
3.				____-____-____
4.				____-____-____

Section 6

1. I have read the Notice of Right to Continue Health Benefits and hereby request that my health coverage be continued. I understand that failure to make timely payments will result in loss of coverage.

_____ _____

(Signature) (Date)

2. I have read the Notice of Right to Continue Health Benefits and hereby decline my right to continue health coverage made available to me due to the qualifying event indicated.

_____ _____

(Signature) (Date)