

News Statement

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Statement of Phyllis C. Borzi on COBRA subsidy extension

**Washington, DC** – Phyllis C. Borzi, Assistant Secretary of the Employee Benefits Security Administration (EBSA) today released the following statement regarding the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the recent extension of the premium reduction under the American Recovery and Reinvestment Act (ARRA):

"I am pleased Congress has acted and the President has signed the Fiscal Year 2010 Defense Appropriations Act. The act extends the eligibility period for the COBRA premium reduction for an additional two months (through Feb. 28, 2010) and the maximum period for receiving the subsidy for an additional six months (from nine to 15 months). Millions of unemployed Americans and their families will be better able to afford and keep their health benefit coverage because of this new law.

"Individuals who had reached the end of the reduced premium period before the legislation extended it to 15 months will have additional time to pay the reduced premiums related to the extension. To continue their coverage they must pay the 35% of premium costs by (60 days after date of enactment) or, if later, 30 days after notice of the extension is provided by their plan administrator.

"We encourage you to subscribe to our COBRA Web site, [www.dol.gov/cobra](http://www.dol.gov/cobra), to get information on new notice requirements, updated guidance, fact sheets, and frequently asked questions as they become available.

"Individuals should contact their plan or health insurance provider for information regarding the extension under their health plan. If you need further assistance contact an EBSA Benefits Advisor toll-free at 1-866-444-3272."

U.S. Department of Labor news releases are accessible on the Department's [Newsroom](#) page. The information in this news release will be made available in alternate format (large print, Braille, audio tape or disc) from the COAST office upon request. Please specify which news release when placing your request at 202.693.7828 or TTY 202.693.7755. The Labor Department is committed to providing America's employers and employees with easy access to understandable information on how to comply with its laws and regulations. For more information, please visit the Department's [Compliance Assistance](#) page.

# FEDERAL "COBRA" CONTINUATION COVERAGE FORM

To: \_\_\_\_\_ (Date Notified)  
(Name of Employee or Qualified Beneficiary) (Now covered under I.D. #)

From: \_\_\_\_\_ (Group Number)  
(Name of Group)

RE: Right to Continuation Coverage

This is to advise you that you and/or your covered family members have the right to continuation coverage under the employer's group health plan. Each person covered on the day your health plan is terminated can elect continuation coverage. Your group health plan might include other options, such as dental or cancer coverage. Consult the Group Administrator to determine if you are eligible.

You must exercise this right by notifying your employer within 60 days from the date your coverage terminates because of a "qualifying event" or from the date you receive this notice, whichever is later. Your coverage will terminate as a result of a qualifying event. When your election notice is received, your coverage will be reinstated.

As a result of the "qualifying event", your coverage terminates \_\_\_\_\_. Therefore, continuation coverage will end \_\_\_\_\_.

You and/or your covered dependents are entitled to continuation coverage for the specified time because of the following qualifying event. If it is for 36 months, a new Enrollment Form and Request for Change Form must be completed.

### 18 Months

- Termination of employment
- Loss of coverage due to reduction in work hours

### 36 Months

- Death of employee
- Divorce/Separation From Employee
- Ineligible dependent child
- Medicare-ineligible spouse/children

The monthly premium due for continuation coverage is \$ \_\_\_\_\_ for subscriber only coverage; \$ \_\_\_\_\_ for employee and dependent coverage, provided your dependents were previously insured. These applicable rates can include 102 percent of the group premium amount of 150 percent of the group premium amount for disability.

You must submit the monthly premium to our company no later than the \_\_\_\_\_ of each month. Failure to pay premiums timely will result in cancellation.

Certain disabled qualified beneficiaries can have an 11-month extension from 18 months to 29 months. To qualify, a qualified beneficiary must be determined by the Social Security Administration to be disabled as of the termination or reduction in hours of employment or within sixty (60) days thereafter. In order to qualify for the 11-month extension, the Plan Administrator (employer) must be notified within 60 days after the SSA notice of disability. In addition, that notification to the employer must be made during the initial 18-month coverage period, while Cobra coverage remains in force. In such cases, the qualifying beneficiary may be charged 150 percent of the group fee for the 11-month extended period. The Plan Administrator must forward the award letter to the insurance carrier for an additional 11 months of coverage. The affected individual must also notify the Plan Administrator within thirty (30) days of any final determination that the individual is no longer disabled.

**TO BE COMPLETED BY EMPLOYEE/QUALIFIED BENEFICIARY**

I acknowledge receipt of the above notice of right to continuation coverage.

For myself and family members, if any, I elect

- ( ) Not to have continuation coverage
- ( ) To have continuation coverage, and understand that I am responsible for payment of the entire premium amount/102 percent of the group premium or 150 percent of the group premium for disability.

I understand that continuation of coverage ceases at the expiration of the allowed time period. It can end earlier in case of the following:

1. All of the employer's health benefit programs are terminated.
2. A qualified beneficiary becomes covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary.
3. A qualified beneficiary becomes entitled to Medicare after the date of the continuation coverage election. [ If a qualified beneficiary is already entitled to Medicare before the qualifying event, the qualified beneficiary is entitled to elect COBRA ]
4. A qualified beneficiary fails to pay a required premium in a timely manner.
5. A qualified beneficiary with coverage for up to 29 months due to disability has received a final determination that the individual is no longer disabled.

Signature: \_\_\_\_\_  
**EMPLOYEE/QUALIFIED BENEFICIARY**

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



Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.