



**Iowa Schools Employee Benefits Association
COBRA Election Form**

ISEBA USE ONLY	
Date Election Rec'd	/ /
Date Initial Premium Due	/ /
Client Code Assignment	

EMPLOYER SECTION:

Employer Name: _____ Client Code Number: _____

Employee's Name: _____ Social Security Number: _____

Qualified Beneficiary: _____ Employee's Date of Birth: ____ / ____ / ____

Qualified Beneficiary's relationship to the member: Self Spouse Child(ren) Former Spouse

Please indicate the COBRA qualifying event and specify the date of the qualifying event.

Date of Qualifying Event ▼

- Termination of Covered Employee's employment
- Reduction in hours of Covered Employee's employment
- Covered Employee's child has ceased to be a dependent
- Divorce from Covered Employee
- Death of Covered Employee
- Covered Employee's entitlement to Medicare
- Employer Bankruptcy

➤ Is termination of employment or reduction of work hours due to a disability? Yes No

➤ If yes, has the qualified person applied for Social Security due to disability? Yes No

If yes, please refer the qualified person to the **DURATION OF COBRA COVERAGE SECTION** and advise the qualified person to notify you within 60 days of receiving the Social Security Notice of Determination in order to qualify for the 11-month extension of COBRA.

➤ Indicate the qualified person's coverage at the time of the qualifying event: ► Medical & RX Vision Dental

➤ Were dependents also covered? Yes No

MONTHLY PREMIUM CHARGE	Medical & RX	Vision	Dental	Total Premium
Specify Policy: PPO 100, HSM, dental policy number ►				
Individual	\$	\$	\$	\$
Individual + one dependent	\$	\$	\$	\$
Individual + 2 or more dependents	\$	\$	\$	\$

- An additional 2% COBRA billing fee may apply.
- For single Dependents electing COBRA continuation, the rate charged will be the individual rate.
- The grace period for payments, other than your initial premium payment is 30 days.
- These rates are subject to change based on the employer-sponsored plan.

➤ Indicate the date the qualified beneficiary will lose group coverage based on the plan provisions. ____ / ____ / ____

➤ The date the qualified beneficiary has been provided this election form: ____ / ____ / ____

Date Election is Due: ____ / ____ / ____ *The election due date is calculated 60 days from the loss of group coverage or the date the qualified beneficiary has been provided the election form, whichever is greater.*

- Mail the completed election form to Employer on or before **Date Election is Due**.
- Mail the completed election form to ISEBA on or before **Date Election is Due**:
ISEBA 6000 Grand Avenue, Des Moines, Iowa 50312

Authorized Signature of Employer

Title

Date signed

QUALIFIED BENEFICIARY ELECTING COBRA CONTINUATION, PLEASE READ THIS SECTION CAREFULLY:

You must send the completed COBRA Election Form on or before the **Date Election is Due** to the address indicated on PAGE 1 of the application. The election period ends 60 days after the date of this Notice or 60 days after your plan coverage ends, whichever period is longer. You will lose your eligibility for COBRA coverage if you fail to send the Election Form by the **Date Election is Due**.

Initial payment of premiums for COBRA coverage must be made on or before the 45th day after electing COBRA coverage. Your initial payment must be at least enough to pay for the premiums for all prior months of continuation coverage, not including the month in which you are making the initial payment.

No claims under continuation coverage are paid until the premium for the month of coverage is paid. *If the full initial premium payment is not made within the 45-day period, coverage for the affected qualified beneficiary remains canceled and no COBRA coverage will be provided.* If, for whatever reason, any qualified beneficiary receives any medical benefits under the Plan during a month for which the premium was not paid timely, you will be required to reimburse the Plan for the benefits received.

Indicate if coverage is to be continued: Yes If Yes, complete the items below.
 No If No, please sign and date the form and return it to your employer. NOTE: If you are rejecting COBRA continuation for yourself and/or your family, your spouse must also sign where indicated.

_____/_____/_____
 Signature of Qualified person rejecting COBRA Date Signed Signature of Spouse of rejecting COBRA Date Signed

Your right to elect continuation coverage applies only to the Plan(s) under which you were covered on the **Date of the Qualifying Event**. Continue the follow coverage(s) **Medical & RX**
 Vision
 Dental

Dependents may be continued only if they were covered under the group health plan on the date of the qualifying event. Dependents acquired during the continuation period may be eligible for coverage. Please refer to the HIPAA Special Enrollment Rights Section in the Continuation of Group Health Coverage notice. Continue coverage for **Member only**
 Member & Dependent(s) (list below)
 Dependent(s) (list below)

Last Name	First Name	Social Security #	Date of Birth	Sex M/F	Relationship to Member

➤ If you, your spouse or dependents, are enrolled in another insurance program or Medicare, please provide the following information.

Name of Employer: _____ Effective Date: ____/____/____
 Name of Insured: _____ Is Coverage Still in Effect? Yes No
 Name of Insurance Carrier: _____ Insurance Carrier Phone #: _____

➤ Have you or any of your Dependents been determined disabled by the Social Security Administration? Yes No
 If yes, please provide the following information:

Name of Person Disabled: _____ Date of Social Security determination: ____/____/____
 Relationship to Member: _____ **Please attach a copy of the Social Security Notice of Determination.**

Address of Qualified person(s) electing COBRA					
Street Address:					
City:	State:	Zip:	Home Phone #:	Work Phone #:	

- I hereby certify that to the best of my knowledge the above statements are correct.
- I have read and understand the Continuation of Group Health Coverage as outlined at the beginning of this form.
- I understand that omissions or misleading statements may constitute insurance fraud, which is punishable by law.

_____/_____/_____
 Qualified Beneficiary's signature Date signed