



CALIFORNIA STATE UNIVERSITY, FRESNO
COBRA QUALIFYING EVENT (ELECTION) NOTICE

Date: _____

To: Covered Employee, Spouse, Registered Domestic Partner and Dependent Children

From: California State University, Fresno
 Human Resources Office

This notice contains important information about your right to continue your group health care coverage in medical, dental, vision, health care reimbursement account (HCRA) plans (collectively, the “Plan”). Please read the information contained in this notice very carefully. We use the pronoun “you” in this notice (including the enclosed Election Form) to refer to each of the individual addressees named above.

To elect COBRA coverage, follow the instructions on the enclosed *Election Form* and submit the completed form to Human Resources.

Qualifying Event

- | | |
|---|---|
| <input type="checkbox"/> End of employment on (18 months) | <input type="checkbox"/> Reduction in hours of employment (18 months) |
| <input type="checkbox"/> Death of employee (36 months) | <input type="checkbox"/> Divorce or legal separation (36 months) |
| <input type="checkbox"/> Loss of dependent child status (36 months) | <input type="checkbox"/> Dissolution of Registered Domestic Partnership (36 months) |

▪ Date of Qualifying Event: _____

▪ Termination date of regular coverage: _____

▪ Effective date of COBRA continuation: _____ can last until _____
 (Coverage must be continuous, without a break)

▪ If applicable, Effective date of HCRA COBRA continuation: _____ Coverage under the HCRA can last only until December 31, 20__ .

The event designated above that caused you to lose coverage under the Plan(s) are called your “qualifying event” in this notice, and the date of that event shown above is the date of your qualifying event. Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA coverage under one or more group health overages under the Plan specified below.

Eligible for COBRA

- | | | |
|---|--|--|
| <input type="checkbox"/> Employee or former employee | <input type="checkbox"/> Spouse or former spouse | <input type="checkbox"/> Registered Domestic Partner |
| <input type="checkbox"/> Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage | | |
| <input type="checkbox"/> Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan | | |

The current monthly cost of your COBRA coverage is enclosed. (Note that these amounts will change in the future and will most likely be higher than they are now. You will be notified of COBRA premium changes.)

You do not send any payment(s) with this *Election Form*. Important additional information about payment for COBRA coverage is included in the pages following the Election Form. If you have any questions about this notice or your rights to COBRA coverage, you should contact Human Resources (559) 278-2032.

COBRA Coverage Election Form

INSTRUCTIONS: To elect COBRA coverage, complete this Election Form and return it to CSU. Under federal law, you must have 60 days after the date of this qualifying event (election) notice to decide whether you want to elect COBRA coverage under the Plan.

Mail or hand deliver the completed Election Form to: **California State University, Fresno, Human Resources, Joyal Administration 164, 5150 North Maple Avenue, M/S JA71, Fresno, CA 93740-8026 (559) 278-2032.** This Election Form must be completed in writing and returned by mail or hand delivered to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail.

If you do not submit a completed Election Form within 60 days from the date on this notice, you will lose your right to elect COBRA coverage. If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

Read the important information about your rights included in the pages after the Election Form.

I (We) decline enrollment in all COBRA coverages.

I (We) elect COBRA coverage for medical, dental vision plan and/or the HCRA plan. (Collectively, the Plan) as indicated below (you may elect one or more group health coverages under "Coverage elected"):

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)	Coverage elected		
_____	_____	_____	_____	<input type="checkbox"/> medical	<input type="checkbox"/> dental	<input type="checkbox"/> vision
_____	_____	_____	_____	<input type="checkbox"/> medical	<input type="checkbox"/> dental	<input type="checkbox"/> vision
_____	_____	_____	_____	<input type="checkbox"/> medical	<input type="checkbox"/> dental	<input type="checkbox"/> vision
_____	_____	_____	_____	<input type="checkbox"/> medical	<input type="checkbox"/> dental	<input type="checkbox"/> vision
_____	_____	_____	_____	<input type="checkbox"/> medical	<input type="checkbox"/> dental	<input type="checkbox"/> vision
_____	_____	_____	_____	<input type="checkbox"/> medical	<input type="checkbox"/> dental	<input type="checkbox"/> vision

All qualified beneficiaries who were covered under the HCRA will be covered together for HCRA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate HCRA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact Human Resources.

MEDICARE

Is the covered employee, spouse, domestic partner, or any dependent child entitled to Medicare Part A, Part B or both? Yes No If yes, name and date of entitlement (shown on Medicare card): _____.

If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting this *Election Form*, immediately notify Human Resources and the applicable dental and vision carriers/COBRA administrators of the date of your Medicare entitlement at the addresses shown below.

HCRA Participant

I (we) have received and read this entire COBRA Qualifying Event (Election) Notice, including the information regarding "Electing COBRA under the HCRA". I (we) understand that the use-it-or-lose-it rule will continue to apply to the HCRA coverage, if elected, so any unused amounts will be forfeited at the end of the Plan year (December 31). I (we) also understand that no HCRA coverage will be available for subsequent years.

Print Employee Name: _____

Print Cobra Enrollee Name: _____ Telephone: _____

Address/City/Zip: _____

Cobra Enrollee Signature

Date