

## COBRA Continuation Coverage IBIS 125 Advantage Plan Election Notice

Return to: 105/125 Department  
800.258.1415  
515.286.4244 fax

Iowa Bankers Insurance & Services, Inc  
PO Box 6210  
Johnston, IA 50131

Employer Name/Location	Billing/Routing Number
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*Name and address of Employer*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ [Enter date of notice]

Dear: \_\_\_\_\_ [Enter Name of Employee]

This notice contains important information about your right to continue your health care coverage in the health flexible spending account sponsored by your Employer.

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Employer's Health Flexible Spending Account ("Health FSA"). If you have any questions concerning the information in this notice or your rights to coverage, you should contact \_\_\_\_\_  
\_\_\_\_\_ (list name/address/phone # of contact person).

You are currently participating in the Health FSA and have under spent your account for the current Plan Year. If you do not elect to continue your health care coverage under the Health FSA by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on \_\_\_\_\_ [enter date] and you will forfeit amounts in your account due to:

- |   |   |
|---|---|
| <input type="checkbox"/> End of employment      | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee      | <input type="checkbox"/> Divorce or legal separation      |
| <input type="checkbox"/> Enrollment in Medicare | <input type="checkbox"/> Loss of dependent child status   |

The monthly COBRA premium for coverage under the Health FSA is 102% of the monthly premium you were paying via salary reductions before the date of the Qualifying Event. Under COBRA, the Health FSA premium must be paid by check, with after-tax dollars. COBRA coverage will consist of the Health FSA coverage you had before the qualifying event (with the annual limit you had). Unless otherwise elected, your spouse and dependent(s), if any, will be covered too. You, the employee and any spouse and dependent children are listed in the box below:

Employee [enter name] \_\_\_\_\_  
Spouse (or former spouse of employee) [enter name] \_\_\_\_\_  
Dependent children [enter name(s)] \_\_\_\_\_



Note: Each beneficiary has separate election rights and could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. Contact \_\_\_\_\_ at \_\_\_\_\_ for more details.

Because of the event (checked above) that will end your coverage under the Plan, you [*and/or, as appropriate, your spouse, and dependent children*] are entitled to continue your coverage for the remainder of the Plan Year which ends \_\_\_\_\_ (*insert last date of Plan year, for example December 31*). If you elect to continue your coverage under the Plan, your continuation coverage will begin on \_\_\_\_\_ [*enter date*].

**IMPORTANT - To elect continuation coverage you MUST complete the enclosed “Election Form” and return it to us. You may mail it to the address shown on the Election Form [or describe other acceptable means of submission]. The completed Election Form must be post-marked by \_\_\_\_\_ [*enter date*] [or received by \_\_\_\_\_ [*enter date*] if submitted by other means]. If you do not submit a completed Election Form by this date, you will lose your right to elect continuation coverage. Important information about your rights is provided to you on the pages after the Election Form.**

**COBRA CONTINUATION COVERAGE ELECTION FORM**

\_\_\_\_\_  
[Name of Employee/Spouse/Dependent Children (as appropriate)]

**IMPORTANT: This form must be completed and returned by mail or personal delivery. If mailed, it must be post-marked no later than \_\_\_\_\_ [enter date]. Send completed form to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I (We) elect to continue our coverage in the \_\_\_\_\_ [enter name of plan] (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
b. _____			
c. _____			
d. _____			

Type of coverage elected:

Health Flexible Spending Account

**Deadline:** You must sign and date this Health FSA Election Form and mail or personally deliver it to \_\_\_\_\_ (insert name/address/phone #) on or before the date indicated above. If you fail to meet this deadline, you will be deemed to have declined COBRA coverage under the Health FSA.

**Certification & Election:** I have received and read the Election Notice. I elect to continue Health FSA coverage under the provisions of COBRA for myself and for the person(s) listed above. I understand that the use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year. I also understand I will have no Health FSA coverage for subsequent plan years and that my coverage will end at the end of the current plan year.

Signature: \_\_\_\_\_

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

## **IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS**

### **What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee coverage under the group health plan, a covered employee’s spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other similarly situated participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be obtained from \_\_\_\_\_  
\_\_\_\_\_ (insert name/address/phone #)

### **How long will continuation coverage last?**

Unlike for other types of group health plans, COBRA coverage under a health flexible spending account is only for the remainder of the Plan Year if you have under spent your account and have a positive balance as of the date of the qualifying event.

Continuation coverage will be terminated before the end of the Plan Year if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### **How can you elect continuation coverage?**

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee’s spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

### **How much does continuation coverage cost?**

For health flexible spending accounts, the premium is 102% of the amount you were paying for a month via salary reductions prior to the qualifying event.

### **When and how must payment for continuation coverage be made?**

#### **First payment for continuation coverage**

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date of Election Notice is post-marked, if mailed.) If you do not make your first payment

for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact \_\_\_\_\_ (*insert name/phone #*) to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Periodic payments for continuation coverage**

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Each subsequent payment is due on the first day of the month to cover that month. Premiums are subject to change and you will be notified if and when a premium has changed. The Plan, however, will not send periodic notices of payments due for these coverage periods. Monthly payments should be made to the address listed above where your first payment is sent.

### **Grace periods for periodic payments**

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

### **Where can I receive more information?**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from \_\_\_\_\_ (*insert name/address/phone #*).

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep Your Plan Informed of Address Changes**

In order to protect your rights and the rights of your family members, you should keep the Plan Administrator and your employer informed of any changes in your address or the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Plan or the Plan Administrator.