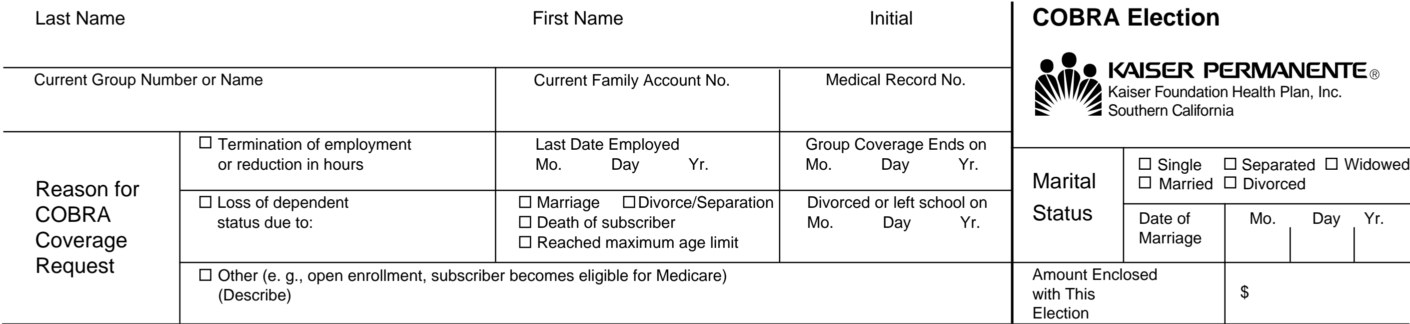

Last Name	First Name	Initial	**COBRA Election** KAISER PERMANENTE® Kaiser Foundation Health Plan, Inc. Southern California
Current Group Number or Name	Current Family Account No.	Medical Record No.	

Reason for COBRA Coverage Request			
	☐ Termination of employment or reduction in hours	Last Date Employed Mo. Day Yr.	Group Coverage Ends on Mo. Day Yr.
	☐ Loss of dependent status due to:	☐ Marriage ☐ Divorce/Separation ☐ Death of subscriber ☐ Reached maximum age limit	Divorced or left school on Mo. Day Yr.
	☐ Other (e. g., open enrollment, subscriber becomes eligible for Medicare) (Describe)		

Marital Status	☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced	
	Date of Marriage	Mo. Day Yr.
Amount Enclosed with This Election	$	

1	I am applying for COBRA Coverage for myself and my eligible family members listed on the reverse. In the event that the group or account that I am leaving reports a termination date that is different from the date this COBRA Coverage membership was established, I understand that my individual account will be credited or debited accordingly. If my account is debited because of a termination date difference, I agree to pay any additional amount due in order to continue my membership.
2	**I understand, except for small claims court cases, any claim that I, my heirs, or other claimants associated with me, assert for alleged violation of any duty arising out of or relating to membership in Health Plan (which provides HMO and In-Network Point-of-Service benefits), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision does not apply to disputes with Kaiser Permanente Insurance Company or disputes arising from Out-of-Network services. Note: A different arbitration provision applies for Federal Employees Health Benefits Program and CalPERS groups. Please contact Member Services for the applicable arbitration provision.**

Important! Complete reverse side of this form.

Elector's Signature	Date Signed
X	

Continuation of Group Coverage

The federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires employers of 20 or more employees (except church employers) to provide a continuation of group coverage to employees and dependents who would normally lose group coverage. COBRA requires that employers notify the qualifying person about the right to continue coverage when loss of group eligibility occurs. Cost is to be paid entirely by you. Your employer will not contribute toward the cost of this plan.

You and your dependents may be eligible to receive uninterrupted COBRA Coverage if you are a qualified beneficiary as defined below.

COBRA Coverage is available for up to 18 months (or up to 29 months if the employee is disabled at time of qualifying event) to:

- A subscriber and dependents, when the subscriber terminates employment with the group through which he/she is enrolled for reasons other than gross misconduct;
- A subscriber and dependents, when the subscriber's hours are reduced to less than part-time and he/she no longer qualifies for group coverage.

COBRA Coverage is available for up to 36 months to:

- A spouse who loses group membership because of divorce or legal separation;
- A spouse who loses group membership due to the death of the subscriber;
- A dependent child who marries or reaches the age limit for group membership, or experiences a change in custody;
- Other reasons specific to your group.

Coverage

Your benefits with continuation coverage will be identical to your present benefits and are subject to change if the group coverage changes. COBRA Coverage begins when your group coverage ends.

Continues on reverse side

Your Social Security No.	DO NOT WRITE IN TINTED AREAS	Group No.	Enroll. Start Date

List Below: Yourself and all other family members to be covered by this enrollment. Only your spouse and unmarried dependent children may be included.

	Last Name (Print)	First Name	Init.	Check One		Birthdate Mo. Day Yr.	RSN	Med. Rec.	Supp. ID Dep.	Supp. CPN Med.
Self				Male ☐	Female ☐				0	0
Spouse				Husband ☐	Wife ☐				1	0
Child				Son ☐	Daughter ☐				2	0
Child				Son ☐	Daughter ☐				2	0
Child				Son ☐	Daughter ☐				2	0
Child				Son ☐	Daughter ☐				2	0
Child				Son ☐	Daughter ☐				2	0
Child				Son ☐	Daughter ☐				2	0

Subscriber's Address	Number/Street	Apt. No.	City	State	Zip Code
Daytime Phone No.	Area Code ( )	Number			

8/96 40-540-97/E9510–20M

Continued from other side

How to Elect

If you or your dependents are eligible and wish to elect COBRA Coverage:

1. *Complete and sign the attached COBRA Coverage election form. Make sure that you've included the names and birth dates of each of your dependents.*
2. *Obtain the applicable Health Plan dues rate from your personnel or human resources department.*
3. *Mail the completed election form and payment* in the return envelope to:*

   Kaiser Permanente Medical Care Program
   California Service Center
   P.O. Box 23127
   San Diego, CA 92193-9918

   *Payment will be due 45 days from receipt of this election form and must reflect premiums due since the termination of your Group Coverage.

Rates

To determine the amount of your monthly payments, please contact your employer for rate information.

You alone ____________________

You and one family member ____________________

You and two or more family members ____________________

Upon receipt of your payment and the election form, we will establish your account and provide you with monthly payment information. **Please contact our Customer Service Call Center at 1-800-464-4000 if you have any additional questions.**