



C.O.B.R.A. election form

Your Kaiser Permanente benefits will terminate on _____. Please complete this form if you wish to continue your current Kaiser Permanente benefits and return the form to the _____ Department, no later than _____. Although you have 45 days from your COBRA election to submit your first month's payment, your COBRA coverage is not effective until the first month's payment is received.

Your name: _____ Member Identification # _____

Mailing Address: _____

Phone: _____ Social Security Number: _____

Names of persons to be covered*	Sex	Date of birth	Relationship to Subscriber

*PLEASE INDICATE if deleting dependents or keeping dependents only and deleting subscriber.

I do hereby elect to continue coverage for the above-listed person(s) under the Kaiser Permanente Medical Plan. I realize that I will be responsible for the full cost of this coverage, plus 2% at \$_____ payable monthly. My Kaiser Permanente plan is meant to provide coverage within the Hawaii service area. If we move outside the service area, our membership may be terminated by Health Plan upon 15 days notice. Outside the Hawaii service area, only emergency services are covered (in accord with my plan benefits) before termination of membership.

X _____ Date
Signature of Applicant (or parent or legal guardian for applicant under 18)

Employer's personnel use only

Group name: _____
Group# Subgroup# Billgroup#

Group administrator: _____

Group address: _____

Kaiser Permanente representative: _____

Billing procedure requested

- Continue on current bill-code as COBRA
- Directly bill member after first month's initial payment
- Establish new group number and billing
- Eighteen (18) months
- Thirty-six (36) months
- Certified Disabled by SSA (not to exceed 29 months)

Date coverage begins _____
Month / Day / Year

Complete and mail to: Kaiser Foundation Health Plan, Inc.
Membership Administration
P.O. Box 30820
Honolulu, HI 96820-0820

C.O.B.R.A. guidelines and procedures

The Consolidated Omnibus Budget Reconciliation Act (COBRA) **applies to all employers with 20 or more employees on a typical business day, except certain church plans and certain governmental plans.**

The law requires that an employer offer continuation coverage for a period of 18 or 36 months to people who would otherwise lose coverage as a result of certain “qualifying events.” For example:

- termination (other than for gross misconduct)
- death of a covered subscriber
- divorce
- loss of dependency status
- a covered subscriber’s entitlement for Medicare

The charge for coverage may not exceed 102% of the applicable premium.

Kaiser Foundation Health Plan offers Employers one of the following three methods of enrolling and accounting for their employees and/or their dependents who elect continuation coverage:

1. Identify subscribers on your regular group billing with a “COBRA-18,” “COBRA-29” or “COBRA-36” notation in the Remarks section for affected subscribers and their families if the entire family is changing to COBRA status. If only certain individuals within a family are changing to this new status, an enrollment form should be completed for them, checking the DELETE DEPENDENT box and writing “COBRA-18,” “COBRA-29” or “COBRA-36” across the face of the form. For disabled “COBRA-29” beneficiary, please attach Social Security Administration’s certification of disability to the form.
2. Establish a separate group billing for COBRA subscribers by calling your Kaiser Permanente Representative or the Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (neighbor islands). This option is recommended only for groups with a significant number of COBRA subscribers.
3. Each COBRA subscriber may be billed individually as a “direct pay account.” To establish individual billings, the Employer should advise the affected employee to submit a completed COBRA election form and the first month’s premium dues (at 102%) within 45 days of COBRA election to:

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Thereafter, each COBRA subscriber will be billed monthly at his/her home address. Upon establishment of the “direct pay account,” you will be informed of the special account number and will be sent a monthly report listing your COBRA participants. The sample election form on the front may be photocopied for use if your company has not developed one.

Your Kaiser Permanente Representative can assist you in arranging continuation coverage for your COBRA-eligible employees. Questions regarding further details of the law should be addressed by your legal counsel or benefits administrator.