

Created on: September 10, 2005

Last Modified on: April 6, 2006

SR81264 Requirements
COBRA Election Notice IDOCs

Objective:

To provide a personalized notification for employees who become eligible for COBRA continuation

Project Type:

This is a PPS enhancement.

Requested by:

HR&B Health and Welfare Administration

Analyst:

Carrie Gatlin

Due Date(s):

This project is Not Urgent.

HR&B Health and Welfare Administration has requested that this enhancement be in place by May 2006.

Background:

In May of 2004, the Department of Labor published final regulations governing the Consolidated Omnibus Budget Reconciliation Act (COBRA) which became effective for calendar year plans on January 1, 2005. These regulations stipulated new requirements for notifying employees, retirees, and their covered dependents ("qualified beneficiaries") of the opportunity to continue their health care benefits when there is a "qualifying event" resulting in the loss of coverage.

Employers with 20 or more employees are subject to COBRA, which allows employees, retirees, and their covered dependents ("qualified beneficiaries") to continue health care coverage under the employer's group plan when coverage is ended due to a qualifying event.

Qualifying events include:

- Separation (for reasons other than gross misconduct)
- Layoff
- Retirement
- Reduction of hours resulting in loss of coverage
- Approved leave without pay
- Divorce/legal separation/annulment
- Termination of domestic partner relationship
- Death of employee/retiree
- Loss of dependent status

The length of COBRA coverage is either 18 or 36 months, depending on the qualified event. In the event of separation, layoff, retirement, reduction of hours, and leave without pay, the employer has 44 days after the qualifying event or coverage end date (whichever is later) to notify the employee. For other events, the University does not have 44 days to notify the employee. In the cases of loss of coverage due to the employee's or retiree's divorce, legal separation, annulment, termination of domestic partnership, death, or a dependent's loss of eligibility, the employer must send an application packet within 14 days of being notified of the event. In this case the application packet must be sent to the qualified beneficiary or legal representative reporting the event.

New under the final regulations is the requirement that the employee and any other qualified beneficiaries must each be given notification of the right to elect COBRA coverage. Previously, employers could address the COBRA notification to the employee and "qualified beneficiaries" in general when sending notification to one address. Under the new regulations, the notification must state either the name(s) or the relationship(s) of the qualified beneficiaries.

Current Process:

When an employment qualifying event occurs, or when a qualified beneficiary notifies the location of a qualifying event, the Benefits Office, department benefits representative, or designated department administrator accesses the Exchange website, an HR&B file-sharing website, to retrieve documents for the COBRA Application Packet. These documents include:

- COBRA cover letter (with enterable fields)
- Application for COBRA Continuation form, UBEN 102 (with enterable fields)
- COBRA Mailing Address and Premium Information (with enterable fields)
- Your COBRA Continuation Coverage Rights--Important Information

The Benefits Office or department representative enters the personalized information, prints the documents, signs the form, and mails or hand-delivers the packet to the qualified beneficiary. The Benefits Office or department must retain a copy of the form or packet for the employee's file, to document that COBRA materials were provided in a timely manner.

Proposed Process:

In the proposed process, new IDOCs are developed to provide the COBRA notification cover letter/application for COBRA Continuation. The PPS user would select the IDOC corresponding to the appropriate qualifying event, and the document printed would be the customized COBRA notification letter, with data specific to the employee.

The campus office would include the generalized COBRA Application Packet (COBRA Mailing Addresses and Premium Information and Your COBRA Continuation Coverage Rights--Important Information) along with the personalized notification letter/application, and either hand deliver or mail the packet to the qualified beneficiary.

IDOCs would be available for the following COBRA qualifying events:

- Separation (for reasons other than gross misconduct)
- Layoff
- Retirement
- Reduction of hours resulting in loss of coverage
- Approved leave without pay

For the remaining qualifying events where a system data element or action may not be identified, or where appropriate addressing information may not be available, locations would continue to utilize their existing manual processes to notify eligible employees and dependents.

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Requirements:

1.0 IDOC Document Selection Menu

The IDOC Document Selection Menu screen should be modified to include a label for the new COBRA IDOCs. Selecting this menu option should generate a secondary selection screen listing the individual COBRA IDOC options as shown in Attachment A.

The screen level Help text for the secondary selection screen, IPPA, should be modified to read as follows:

Function: The IPPA screen has three formats supporting a second level of selection for IDOCs. The 'Status Change Pers. Actions' format is presented for Change in Status IDOCs, and allows the user to select two personnel actions. The 'Leave/Sabbatical Pers. Action' format is presented for Leave and Sabbatical IDOCs, and allows the user to specify the type of leave or sabbatical. The 'COBRA Notification Actions' format is presented for COBRA Notification IDOCs, and allows the user to specify the type of COBRA notification.

Nature of Information: Each of the screen formats presents information identifying the employee record for which the notification is being requested, and a list of secondary selection criteria to be used to prepare the notification.

2.0 General COBRA IDOC Data

For each COBRA IDOC, the system should print the data listed below, per the suggested layout for the specific event (see section 3.0). The system should then insert a page break and print a duplicate copy of the data. The footer of the first copy should be labeled “Employee Copy”. The footer of the duplicate copy should contain the text, “Retention by Benefits Office/Department”.

Any data values not present on the employee’s EDB record should be left blank on the IDOC. It is the responsibility of the local campus offices to ensure that data has been input into the system before printing the IDOC.

The following employee data should be printed on the COBRA IDOCs:

- Notice Date (‘IDOC Print Date’), the date on which the IDOC is printed
- Employee First Name (EDB 0250), Last Name (EDB 0252), and Address as printed on all standard IDOCs
- Employee Date of Birth (EDB 0107)
- Employee Sex Code (EDB 0108)
- Date of the qualifying event: for separation, layoff, and retirement, the qualifying event date is the Date of Separation (EDB 0140). For “reduction of hours”, it is the BELI Change Date (EDB 0183), and for “approved leave without pay” it is the Leave of Absence Begin Date (EDB 0137).

- Medical Plan Code (EDB 0292), if enrolled, translated from Code Translation Table
For medical coverage, the employee should be considered enrolled if:
 - he or she has a Plan Code that is not blank, 'DM' (medical plan not yet selected by the employee), 'XX' (opted out of medical), 'XC' (cancelled medical), or 'XD' (de-enrolled), and
 - the Coverage End Date (EDB 0300) is not prior to the current date, and
 - the Coverage Effective Date (EDB 0294) is not after the current date
- Medical Plan Coverage Code (EDB 0293), if enrolled, translated from Code Translation Table
- Medical Coverage End Date (EDB 0300), if enrolled
- Dental Plan Code (EDB 0272) if enrolled, translated from Code Translation Table
For dental coverage, the employee should be considered enrolled if
 - he or she has a Plan Code that is not 'DD' (dental plan not yet selected by the employee), 'XX' (opted out of dental), 'XC' (cancelled dental), or 'XD' (de-enrolled), and
 - the Coverage End Date (EDB 0271) is not prior to the current date, and
 - the Coverage Effective Date (EDB 0274) is not after the current date
- Dental Plan Coverage Code (EDB 0273) if enrolled, translated from Code Translation Table
- Dental Coverage End Date (EDB 0271), if enrolled
- Vision Plan Code (EDB 0347) if enrolled, translated from Code Translation Table
For vision coverage, the employee should be considered enrolled if:
 - he or she has a Plan Code that is not 'DV' (vision plan not yet selected by the employee), 'XX' (opted out of vision), or 'XD' (de-enrolled), and
 - the Coverage End Date (EDB 0346) is not prior to the current date, and
 - the Coverage Effective Date (EDB 0349) is not after the current date
- Vision Plan Coverage Code (EDB 0348) if enrolled, translated from Code Translation Table
- Vision Coverage End Date (EDB 0346), if enrolled
- COBRA Begin Date (derived, see section 2.2)
- Election form due date (derived, see section 2.3)

2.1 Dependent Data

The following dependent data should be included for all dependents currently enrolled:

- Dependent Name (EDB 0633)
- Dependent Date of Birth (EDB 0634)
- Dependent Sex Code (EDB 0637)
- Dependent Relationship to Employee Code (EDB 0635), translated
- Current enrollment status in medical, dental, and vision coverage: if a dependent is currently enrolled, the IDOC should print "Yes ()" in the appropriate field. If the dependent is not enrolled, the IDOC should print "No".

Dependents are deemed currently enrolled if there is a Coverage Effective Date value and either there is no Coverage End Date, or the Coverage End Date is equal to or later than the employee's Coverage End Date for the corresponding plan. The following examples illustrate how the system should determine which dependents are currently enrolled and what to print on the IDOC for each dependent record ('Yes') or 'No').

Employee 1, Separation Date (EDB 0140) = 03/15/06
 Medical Coverage and End Date = UAC, Self and Family; 04/30/06
 Dental Plan Coverage and End Date = UAC, Self and Family; 04/30/06
 Vision Plan Coverage and End Date = UAC, Self and Family; 04/30/06

Dep	Medical			Dental			Vision		
	Eff Date	End Date	Print	Eff Date	End Date	Print	Eff Date	End Date	Print
01	01/01/06		Yes()	01/01/06		Yes()	01/01/06		Yes()
02	01/01/06		Yes()	01/01/06		Yes()	01/01/06		Yes()
03	01/01/06	04/10/06	No	01/01/06	04/10/06	No	01/01/06	04/10/06	No

Dependents 01 and 02 have coverage effective dates but no end dates for their plans, and thus are deemed "enrolled" at the time of the COBRA event. Because dependent 03's coverage in each plan ended prior to the employee's coverage end date in the corresponding plans, the dependent is not eligible for COBRA continuation.

Employee 2, Separation Date (EDB 0140) = 03/15/06
 Medical Coverage and End Date = UAC, Self and Family; 04/30/06
 Dental Plan Coverage and End Date = UAC, Self and Family; 04/30/06
 Vision Plan Coverage and End Date = U, Self; 04/30/06

Dep	Medical			Dental			Vision		
	Eff Date	End Date	Print	Eff Date	End Date	Print	Eff Date	End Date	Print
01	01/01/06		Yes()	01/01/06		Yes()			No
02	01/01/06		Yes()	01/01/06		Yes()			No
03	01/01/06		Yes()	01/01/06		Yes()			No

The dependents have no coverage effective dates in the vision plan. Therefore they are not currently enrolled and not eligible for COBRA continuation.

Employee 3, BELI Change Date (EDB 0183) = 03/01/06
 Medical Coverage and End Date = UAC, Self and Family; 3/31/06
 Dental Plan Coverage and End Date = UAC, Self and Family; 3/31/06
 Vision Plan Coverage and End Date = UAC, Self and Family; 3/31/06

In this example, Dependent #03's vision coverage has ended prior to the employee's vision coverage end date. Therefore, the dependent should not be eligible for COBRA continuation in the vision plan.

Dep	Medical			Dental			Vision		
	Eff Date	End Date	Print	Eff Date	End Date	Print	Eff Date	End Date	Print
01	01/01/06		Yes()	01/01/06		Yes()			Yes()
02	01/01/06		Yes()	01/01/06		Yes()			Yes()
03	01/01/06		Yes()	01/01/06		Yes()	01/01/06	03/12/06	No

2.2 Derived COBRA Begin Date

The COBRA IDOC should include a “COBRA Begin Date” where noted in the suggested layout. The system should derive a “COBRA Begin Date” equal to one day after the Medical Coverage End Date (EDB 0300). For instance, if the Medical Coverage End Date is ‘02/28/06’, the COBRA Begin Date should be displayed as ‘03/01/06’.

If the employee does not have any current medical coverage, the program should use the Dental Coverage End Date (EDB 0271) to derive the COBRA Begin Date. If the employee has neither current medical coverage nor current dental coverage, the program should use the Vision Coverage End Date (EDB 0346) to derive the COBRA Begin Date. Otherwise, if there is no current coverage, the COBRA Begin Date should be blank.

2.3 Election Form Due Date

The system should derive and print an “Election Form Due Date” on the IDOC. This date should be 60 days after the ‘IDOC Print Date’ (the actual current date on which the IDOC is printed).

3.0 COBRA Events

3.1 Separation

The COBRA Separation IDOC should display the requested data per the suggested layout in Attachment B.

3.2 Layoff

The COBRA Layoff IDOC should display the requested data per the suggested layout in Attachment C. The layout and text is identical to that of the “separation” IDOC (section 3.1) with the exception of the qualifying event label.

3.3 Retirement

The COBRA Layoff IDOC should display the requested data per the suggested layout in Attachment D.

3.4 Reduction of Hours

For the Reduction of Hours event, the system should print the BELI Change Date (EDB 0183) as the date of the qualifying event. See Attachment E for suggested document layout.

3.5 Approved Leave without Pay

For the Approved Leave without Pay event, the system should print the Leave of Absence Begin Date (EDB 0137) as the date of the qualifying event. Because employees on approved leave without pay may elect to continue coverage by paying their full premium, coverage end dates may not be present on the EDB. If no coverage end dates are set, these data as well as the COBRA Begin Date should be left blank on the IDOC. The Benefits representative or department administrator will write in the appropriate dates.

See Attachment F for suggested layout.

Attachment A: IDOC Document Selection Menu

PPIDOC0-I1595 Employee Documents 03/07/06 11:22:28
02/27/06 14:51:44 Document Selection Menu Userid: PAYCMP0
ID: 333333039 Name: AARDVARK, FRANCIS Emp Stat: A Pri Pay: MO
Page 2 of 2

Separation Documents : Staff
Academic
Student
Layoff

Personnel Summary Documents : All - Landscape
All - Portrait

Benefits Summary Documents : Benefits Enrollment
Retirement and Savings

COBRA Notification Documents : _ All

Next Func: ID: Name: SSN:

====>

F: 1-Help 2-Cancel 3-PrevMenu 4-Print 5-GenDoc
F: 7-Backward 9-Jump 12-Exit

PPIxxx0-I1595 Employee Documents 09/20/05 09:35:16
09/06/05 16:53:16 COBRA Notification Documents Userid: PAYCMP0
ID: 333333039 Name: AARDVARK, FRANCIS Emp Stat: A Pri Pay: MO
Page 3 of 3

COBRA Notification Documents : _ Separation
_ Layoff
_ Retirement
_ Reduction of Hours
_ Approved Leave without Pay

Next Func: ID: Name: SSN:

Attachment B: COBRA IDOC: Separation

Date: 02/16/06
Page 1 of 2

UNIVERSITY OF CALIFORNIA
PAYROLL/PERSONNEL SYSTEM

TO: JANE SMITH
123 ABC LANE
OAKLAND, CA 94612

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Termination of Employment on: 02/05/06¹

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 04/16/06²

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
6. Keep a copy of the form for your records.

1. CURRENT COVERAGE AND DATE COVERAGE ENDS

¹ Date of Separation (EDB 0140)

² Election Form Due Date

The health plan(s) in which you are currently enrolled are indicated below.

Health Net³
 Family Coverage⁴
 coverage termination date: 3/31/06⁵

Delta Dental⁶
 Family Coverage⁷
 coverage termination date: 3/31/06⁸

Vision⁹
 Self Coverage¹⁰
 coverage termination date: 3/31/06¹¹

 2. QUALIFIED BENEFICIARIES

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- * Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- * Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
Jane Smith ¹² () SSN ()	02/02/62 ¹³	F ¹⁴	Employee	Yes()	Yes()	Yes()
Jack Smith ¹⁵ () SSN ()	02/20/59 ¹⁶	M ¹⁷	Spouse ¹⁸	Yes()	Yes()	Yes()
Karen Smith () SSN ()	03/31/82	F	Child	Yes()	Yes()	No

If you elect COBRA continuation coverage, your coverage will begin on: 04/01/06¹⁹

³ Medical Plan Code (EDB 0292), translated
⁴ Medical Plan Coverage Code (EDB 0293), translated
⁵ Medical Coverage End Date (EDB 0300)
⁶ Dental Plan Code (EDB 0272), translated
⁷ Dental Plan Coverage Code (EDB 0273), translated
⁸ Dental Coverage End Date (EDB 0271)
⁹ Vision Plan Code (EDB 0347), translated
¹⁰ Vision Plan Coverage Code (EDB 0348), translated
¹¹ Vision Coverage End Date (EDB 0346)
¹² Employee First Name (EDB 0250) and Last Name (EDB 0252)
¹³ Employee Date of Birth (EDB 0107)
¹⁴ Employee Sex Code (EDB 0108)
¹⁵ Dependent Name (EDB 0633)
¹⁶ Dependent Date of Birth (EDB 0634)
¹⁷ Dependent Sex Code (EDB 0637)
¹⁸ Dependent Relationship to Employee Code (EDB 0635), translated
¹⁹ COBRA Begin Date

3. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

COBRA Continuation Applicant Signature

Date

()

Print Name

Daytime phone

Benefits Representative Signature

Date

()

Campus/lab

Phone

ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

Print Name

Mailing Address (Number, Street, City, State, ZIP)

Attachment C: COBRA IDOC: Layoff

Date: 02/16/06
Page 1 of 2

UNIVERSITY OF CALIFORNIA
PAYROLL/PERSONNEL SYSTEM

TO: JANE SMITH
123 ABC LANE
OAKLAND, CA 94612

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Layoff on: 02/05/06

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 04/16/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
6. Keep a copy of the form for your records.

1. CURRENT COVERAGE AND DATE COVERAGE ENDS

The health plan(s) in which you are currently enrolled are indicated below.

Health Net

Family Coverage
coverage termination date: 3/31/06

Delta Dental
Family Coverage
coverage termination date: 3/31/06

Vision
Self Coverage
coverage termination date: 3/31/06

2. QUALIFIED BENEFICIARIES

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- * Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- * Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
Jane Smith () SSN ()	02/02/62	F	Employee	Yes()	Yes()	Yes()
Jack Smith () SSN ()	02/20/59	M	Spouse	Yes()	Yes()	Yes()
Karen Smith () SSN ()	03/31/82	F	Child	Yes()	Yes()	No

If you elect COBRA continuation coverage, your coverage will begin on: 04/01/06

3. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

COBRA Continuation Applicant Signature

Date

()

Print Name

Daytime phone

Benefits Representative Signature

Date

()

Campus/lab

Phone

ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

Print Name

Mailing Address (Number, Street, City, State, ZIP)

Attachment D: COBRA IDOC: Retirement

Date: 02/16/06

Page 1 of 2

UNIVERSITY OF CALIFORNIA
PAYROLL/PERSONNEL SYSTEM

TO: JANE SMITH
123 ABC LANE
OAKLAND, CA 94612

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Retirement on: 02/05/06

Note: If you are eligible and have made arrangements to continue your UC-sponsored medical or dental coverage into retirement, and you are not enrolled in the vision plan or do not wish to continue your vision coverage under COBRA, please disregard this mailing. However, if you are enrolled in the vision plan and wish to continue your vision coverage under COBRA, use this form to apply. (Vision coverage through UC is not available to retirees.)

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 04/16/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA

Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.

6. Keep a copy of the form for your records.

1. CURRENT COVERAGE AND DATE COVERAGE ENDS

The health plan(s) in which you are currently enrolled are indicated below.

Health Net
Family Coverage
coverage termination date: 3/31/06

Delta Dental
Family Coverage
coverage termination date: 3/31/06

Vision
Self Coverage
coverage termination date: 3/31/06

2. QUALIFIED BENEFICIARIES

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- * Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- * Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
Jane Smith () SSN ()	02/02/62	F	Employee	Yes()	Yes()	Yes()
Jack Smith () SSN ()	02/20/59	M	Spouse	Yes()	Yes()	Yes()
Karen Smith () SSN ()	03/31/82	F	Child	Yes()	Yes()	No

If you elect COBRA continuation coverage, your coverage will begin on: 04/01/06

3. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

COBRA Continuation Applicant Signature

Date

()

Print Name

Daytime phone

Benefits Representative Signature

Date

()

Campus/lab

Phone

ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

Print Name

Mailing Address (Number, Street, City, State, ZIP)

Attachment E: COBRA IDOC: Reduction of Hours

Date: 02/16/06
Page 1 of 2

UNIVERSITY OF CALIFORNIA
PAYROLL/PERSONNEL SYSTEM

TO: JANE SMITH
123 ABC LANE
OAKLAND, CA 94612

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Reduction of Hours on: 02/01/06²⁰

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 04/16/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.
6. Keep a copy of the form for your records.

1. CURRENT COVERAGE AND DATE COVERAGE ENDS

²⁰ BELI Change Date (EDB 0183)

The health plan(s) in which you are currently enrolled are indicated below.

Health Net
Family Coverage
coverage termination date: 2/28/06

Delta Dental
Family Coverage
coverage termination date: 2/28/06

Vision
Self Coverage
coverage termination date: 2/28/06

2. QUALIFIED BENEFICIARIES

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- * Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- * Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
Jane Smith () SSN ()	02/02/62	F	Employee	Yes()	Yes()	Yes()
Jack Smith () SSN ()	02/20/59	M	Spouse	Yes()	Yes()	Yes()
Karen Smith () SSN ()	03/31/82	F	Child	Yes()	Yes()	No

If you elect COBRA continuation coverage, your coverage will begin on: 03/01/06

3. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

COBRA Continuation Applicant Signature

Date

()

Print Name

Daytime phone

Benefits Representative Signature

Date

----- () -----
Campus/lab Phone

ALTERNATE ADDRESS INFORMATION

If any qualified beneficiary electing continuation coverage lives at an address other than the one listed on page 1, provide his/her name and address below to notify your plan carrier(s).

Print Name

Mailing Address (Number, Street, City, State, ZIP)

Attachment F: COBRA IDOC: Approved Leave without Pay

Date: 02/16/06
Page 1 of 2

UNIVERSITY OF CALIFORNIA
PAYROLL/PERSONNEL SYSTEM

TO: JANE SMITH
123 ABC LANE
OAKLAND, CA 94612

This packet contains important information about your right to continue your health plan coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Please read this carefully.

Attached to this Application for COBRA Continuation are the following documents: COBRA Mailing Addresses and Premium Information, and Your COBRA Continuation Coverage Rights-Important Information.

We are providing you with this packet because you are eligible for COBRA continuation coverage due to this qualifying event:

Leave without pay on: 02/01/06²¹

Note: If you are an employee taking a leave without pay and you have arranged to continue your UC-sponsored coverage by making direct payments to your Benefits or Payroll Office instead of electing COBRA continuation, this packet serves as your official notice regarding your COBRA continuation coverage rights.

To elect COBRA continuation coverage for yourself and/or your covered dependents, you must complete this form and submit it to your health plan carrier(s) by this date:

Application due date: 04/16/06

Note: If the carrier(s) do not receive this notice by this due date, you will lose all rights to continue your health coverage under COBRA.

INSTRUCTIONS

To elect COBRA continuation coverage, you must do the following:

1. Complete the "Qualified Beneficiaries" section (Section 2), below.
Note: You may only continue coverage under the plans in which you were enrolled on the day before the COBRA qualifying event. COBRA coverage may be elected for one, several, or all qualified beneficiaries.
2. Review the form carefully to be sure all information is correct.
3. Make sure the form has been signed by your Benefits or departmental representative.
4. Sign and date the form under Section 3.
5. Make photocopies of all pages of this completed Application for COBRA

²¹ Leave of Absence Begin Date (EDB 0137)

Continuation. Send one copy, along with one month's premium, to each health plan carrier (medical, dental, and/or vision) with whom you wish to continue coverage.

6. Keep a copy of the form for your records.

1. CURRENT COVERAGE AND DATE COVERAGE ENDS

The health plan(s) in which you are currently enrolled are indicated below.

Health Net
Family Coverage
coverage termination date:

Delta Dental
Family Coverage
coverage termination date:

Vision
Self Coverage
coverage termination Date:

2. QUALIFIED BENEFICIARIES

Each person ("qualified beneficiary") enrolled in the group plan(s) below is entitled to elect COBRA continuation coverage which may be continued for up to 18 months.

To elect continuation coverage, please do the following:

- * Insert an "X" next to the name of each qualified beneficiary to be covered and include the Social Security Number.
- * Insert an "X" next to the plan(s) you wish to continue for each qualified beneficiary.

Name	Birthdate	Sex	Relationship	Medical	Dental	Vision
Jane Smith () SSN ()	02/02/62	F	Employee	Yes()	Yes()	Yes()
Jack Smith () SSN ()	02/20/59	M	Spouse	Yes()	Yes()	Yes()
Karen Smith () SSN ()	03/31/82	F	Child	Yes()	Yes()	No

If you elect COBRA continuation coverage, your coverage will begin on:

3. SIGNATURES

I agree to pay the total monthly premium directly to the plan carrier(s) in accordance with their procedures. I understand that failure to pay premiums will result in the termination of my group coverage. I also understand that UC will not contribute toward the cost of my group coverage under COBRA.

COBRA Continuation Applicant Signature

Date

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