COBRA COVERAGE ELECTION FORM

Print Employee Name: _____ People Soft # _____

Print Cobra Enrollee Name _____ Telephone: _____
(If different from above):

Address/City/Zip: _____

INSTRUCTIONS: To elect COBRA continuation 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 the completed Election Form to: **California State University, Fresno, Human Resources, Joyal Administration 211, 5150 North Maple Avenue, M/S JA41, Fresno, CA 93740-8026 559.278.2032.** This Election Form must be completed in writing and returned to the 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.

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. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

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"):

☐ Anthem Blue Cross Select* (HMO)	☐ Anthem Blue Cross Traditional* (HMO)	☐ BlueShield Access + Advantage*(HMO)	☐ United HealthCare Alliance* (HMO)	☐ Health Net SmartCare* (HMO)	☐ Kaiser* (HMO)
☐ Pers Platinum (PPO)	☐ Pers Gold (PPO)	☐ PORAC (PPO) *This medical plan is restricted to Unit 8 employees with SUPA membership.			
☐ Delta Dental Care (HMO)	☐ Delta Dental Enhanced (PPO)	☐ Vision Service Plan (Basic)	☐ Vision Service Plan (Premier)		

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)	Coverage elected
_____	_____	_____	_____	☐ medical ☐ dental ☐ vision
_____	_____	_____	_____	☐ medical ☐ dental ☐ vision
_____	_____	_____	_____	☐ medical ☐ dental ☐ vision
_____	_____	_____	_____	☐ medical ☐ dental ☐ vision
_____	_____	_____	_____	☐ medical ☐ dental ☐ 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

If you lose your eligibility to participate in the Health Care Reimbursement Account for any reason during the plan year (i.e., retire, terminate, etc.), you may continue to make contributions on an after-tax basis to your account under the CSU's Continuation of Coverage guidelines. You must have a positive account balance at the time you separate. If you choose not to continue contributions under COBRA, the funds you have already contributed to your account will not be available for reimbursement of expenses you incur after the date you are no longer eligible.

☐ 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. _____ Initials

_____ _____
Signature Date