RIVCO 1HR
putting people first

2025 COBRA Benefit Election Form

Name:	**Social Security#:**	**Employee ID:**	
Street Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Termination Date:**	
Email Address: (if available)			

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides employees and dependents with the right to continue health coverage when coverage is lost for limited periods of time based on certain conditions. Qualified beneficiaries are required to pay the full cost of the insurance plan costs plus a two percent (2%) administration fee. **Please complete ALL fields of this form. Failure to complete the form entirely and accurately may cause a delay in your enrollment.**

PLAN OPTIONS:

- **MEDICAL**: I wish to continue or enroll _____ **medical plan** (you must also complete the PERS-HBD-85 on Pg. 3)
  (Plan Name)
- **DENTAL**: I wish to continue or enroll _____ **dental plan**
  (Plan Name)
- **VISION**: I wish to continue or enroll _____ **vision plan** (as determined by your Bargaining Unit)
  (Plan Name)
- **Health Flexible Spending Account (FSA)**: I am currently enrolled in the Health Flexible Spending Account at **$**_____ per month and wish to participate until the end of the calendar year.

  If you do not choose to continue your participation in the Health Care Flexible Spending Account (FSA) by electing this COBRA option, you will cease to be a participant in the plan. Special rules apply to the deadlines for incurring and claiming eligible expenses. Please refer to the Plan's summary plan document for additional information by logging onto www.ASIFLEX.com or calling the Benefits Information Line at (951) 955-4981 or TTY for Hearing Impaired (951) 955-8688.

  Note: If you were not actively participating in the Health Care Flexible Spending Account (FSA) as an active employee prior to ending your employment, you are not eligible to enroll in the Health Care Flexible Spending Account.

DEPENDENT(S) INFORMATION:

Please complete the requested information for any qualified dependent(s) you want to continue benefits on your medical, dental, vision or Health Flexible Spending Account:

Dependent Name	Relation	Gender	Social Security #	Medical	Dental	Vision	Date of Birth	Provider ID
	SELF	☐ Male ☐ Female		☐ Yes ☐ No ☐ Medicare	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Male ☐ Female		☐ Yes ☐ No ☐ Medicare	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Male ☐ Female		☐ Yes ☐ No ☐ Medicare	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Male ☐ Female		☐ Yes ☐ No ☐ Medicare	☐ Yes ☐ No	☐ Yes ☐ No		
		☐ Male ☐ Female		☐ Yes ☐ No ☐ Medicare	☐ Yes ☐ No	☐ Yes ☐ No		

For Office Use Only

Event Date:_____ **COBRA Start Date:**_____

Reason:_____ **COBRA End Date:**_____

Processed by:_____

Instructions

Initial Enrollment: To elect COBRA continuation coverage, complete this Election Form and return it to the Human Resources Benefits Division. Under Federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for any of your dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any eligible dependent child. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified dependents.

If you do not submit a completed Election Form within 60 days of the qualifying event or date of COBRA eligibility notice you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date and pay all premiums due.

Annual Enrollment: All qualified dependents have independent election rights and are eligible to elect an alternate plan, as if the qualified dependent was an individual employee. If each qualified beneficiary chooses coverage independent from his or her family member, payment will be required for each family under the single coverage rate. If you do not submit a completed Election Form by **October 11, 2024** you will lose your right to elect independent COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date and pay all premiums due.

IT IS MY RESPONSIBILITY TO:

- **Make monthly premium payments by the 25th of the month for the following month's coverage.**
- **Notify Human Resources of changes in my address or dependent coverage.**
- **Notify Human Resources if I or any of my dependents become eligible for Medicare.**
- **Notify Human Resources in writing of my intent to cancel COBRA coverage as soon as possible.**
- **Your first payment for continuation coverage must be made no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.**

MY COBRA INSURANCE WILL CEASE IF:

- I fail to pay premiums in a timely manner. Payments must be received no later than the 25th of each month for the next month's coverage.
- I enroll in another employer's medical, dental or vision group plan.
- Group insurance is terminated for all employees. ***My COBRA benefit(s) will not be reinstated once it is cancelled.**

Send completed Election Form to: **County of Riverside Human Resources Department**
Attn: COBRA Benefits
P.O. Box 1569
Riverside, CA 92502-1569

Retiree

Sometimes, filing proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to The County of Riverside, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Binding Arbitration

I understand that the health plans sponsored by the County of Riverside use neutral binding arbitration to resolve disputes between Members, including but not limited to, claims of malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and the health plan. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceeding. The health plan and myself (and/or any enrolled family member), the parties to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. For additional information about each plan's arbitration provision, I may refer to the Disclosure Form and Evidence of Coverage, copies of which are available from each benefit plan.

Release of Information

I authorize any physician, health care practitioner, hospital or other health care facility, clinic, health care service plan, or any other person or entity to release to any health care plan provider of the County of Riverside, a health care service plan, a self-insurer, or any insurance company, or its designee, all medical or personal information related to myself or any covered dependent, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: Diagnosis or treatment; Payment of health services rendered; Billing, claims management, medical data processing, or other administrative function of the health plan in which I am enrolled through the County; Peer review, including reviewing the competence or qualifications of health care professionals; Utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges; Handling of member grievances or appeals, external independent review, or other health dispute resolution; Coordination of care with providers of health care or other health care service plans; Administering the health benefit plan; Chronic disease management programs, to monitor or administer care of a covered benefit; to verify my participation in other healthcare coverage if I elected to waive County sponsored benefits and other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my health plan provider through the County of Riverside.

I certify that I have read, understand, and agree to the terms outlined on this COBRA Benefit Election Form.

Signature _____ Date _____

Print Name: _____ Contact Phone Number: _____

Only complete the following pages if you wish to continue a CalPERS medical plan.

State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Group Continuation Coverage Consolidated Omnibus Budget Reconciliation Act (COBRA)

Instructions for completing this form are on page 3.

Section 1: Enrollee Information

COBRA Enrollee (may be different than subscriber)

COBRA Enrollee (First Name) (Middle Initial) (Last Name) **Birth Date** (mm/dd/yyyy)

CalPERS ID or Social Security Number (SSN)

Gender: ○ **Male** ○ **Female** ○ **Non-Binary**

Mailing Address (Street) **City** **State** **ZIP Code** **Primary Phone Number**

CalPERS Subscriber (Employee) if different from enrollee

Subscriber Name (First Name) (Middle Initial) (Last Name) **CalPERS ID or SSN**

Section 2: Type of Action

○ **New Enrollment** ○ **Add or Delete Dependent(s)** ○ **Change Health Plan** ○ **Cancel Coverage**

Section 3: Type of Permitting Event

○ **Employment Separation or Time Base Reduction** ○ **Divorce or Legal Separation** ○ **Death of an Employee**

○ **Child Ceases to be a Dependent** ○ **Dependent Eligibility Verification**

○ **Dependent Continuation – Original Enrollee Eligible for Medicare** ○ **SSA Certified Disability – 11 Month Extension**

Event Date (mm/dd/yyyy) **COBRA Enrollment Period** (mm/01/yyyy) **to** (mm/dd/yyyy)

Section 4: Dependent Information

List of all persons to be enrolled (including self).

Name (First M.I. Last)	Relationship	Birthdate (mm/dd/yyyy)	CalPERS ID or SSN	Action	Health/ Dental Changes
	Self			○ Add ○ Delete	☐ Health ☐ Dental
				○ Add ○ Delete	☐ Health ☐ Dental
				○ Add ○ Delete	☐ Health ☐ Dental
				○ Add ○ Delete	☐ Health ☐ Dental

Section 5: Plan Information

Health Plan

Section 6: Signature of Enrollee

I agree to pay the premium for the coverage directly to the plan listed in Section 5. I understand that I am required to make the initial payment within 45 days of election to enroll and agree to make future payments in a timely manner as required by the plan(s). I understand that failure to pay the premium will result in automatic termination of coverage. I certify that the information provided by me is true and correct to the best of my knowledge and ability.

Signature of COBRA Enrollee (see attachment for privacy Information) **Date Signed** (mm/dd/yyyy)

Submit this form to your employer

Please do not submit payment to your employer or CalPERS. You will receive payment instructions from your health plan.

Section 7: Agency Information

Agency Name **Agency Code**

Health Benefit Officer Signature **Date Received** (mm/dd/yyyy) **Primary Phone Number**

Section 8: COBRA Instructions

Section 1: Enrollee Information

a. Provide all requested information
b. Identify the employee if the COBRA enrollee is a former dependent

Section 2: Type of Action

a. Select new enrollment if this is your new/initial enrollment
    i. There cannot be a break in coverage between the end of CalPERS active health coverage and the beginning of COBRA enrollment
b. Select add or delete dependent if you are adding or deleting a dependent
c. Select change health plan if you are changing your health plan
d. Select cancel if you are canceling your COBRA enrollment
    i. If cancel is selected, continue to Section 4

Section 3: Type of Permitting Event

a. Select the appropriate permitting event
b. Provide original event date (permanent separation, divorce date, ect.)
c. Enter COBRA enrollment period (18 or 36 months depending on permitting event)
    i. Example: Permanent Separation date is 4/15/2023 (COBRA Enrollment Period: From 6/1/2023 to 11/30/2024)
    ii. Example: Child attains age 26 on 06/15/2023 (COBRA Enrollment Period: From 07/01/2023 to 06/30/2026)

Section 4: Dependent Information

a. List all dependents to be enrolled, including self (if applicable)
    i. Enter dependent's name, relationship, birthdate, and CalPERS ID number or Social Security Number
    ii. Select applicable action to add if the dependent is being added or newly enrolled
    iii. Select applicable action to delete if the dependent is being deleted from COBRA coverage
    iv. An action is not required when changing carriers
    v. Check Health and/ or Dental to indicate election based on the action
        i. The addition and deletion of dependent is regulated by time limits, which are identical for active employees.

Section 5: Plan Information

a. Complete fields

Section 6: Signature of Enrollee

a. Signature of COBRA enrollee and date signed

Section 7: Agency Information

a. Completed by the current or former employing agency's Health Benefit Officer/ Personnel Office. CalPERS is the employing agency for former departments of retirees.

Important

It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws and time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Section 7.

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested by CalPERS' Information Security Office is collected pursuant to the following authority:

- CA Civil Code §56.10
- CA Civil Code §56.11
- CA Civil Code §56.13
- 45 C.F.R. §164.508

The principal purpose the information will be used for is the administration of duties under the Health Insurance Portability and Accountability Act (HIPAA), as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to process your request.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers (SSN) are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided to CalPERS, disclosure is voluntary. Due to the use of SSNs by other agencies for identification purposes, we may be unable to process your request without its disclosure.

Social Security numbers are used for the following purposes:

1. Member / Representative identification
2. Fulfill Member / Representative requests

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy (https://www.calpers.ca.gov/page/privacy-policy), or your rights, please write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).