2024 COBRA Benefit Election Form

RIVCO 1HR putting people first

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 13, 2023** 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.

CalPERS

Group Continuation Coverage Consolidated Omnibus Budget Reconciliation Act (COBRA) PERS-HBD-85 (Rev 05/21)

Health Account Management Division
P.O. BOX 942715, Sacramento, CA 94229-2715
888 CalPERS (or 888-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545 | **www.calpers.ca.gov**

Instructions for completing this form are on the reverse side. Please type.

PART A: Type of Action and Dates

1. Type of Action	2. Type of Permitting Event	3. Event Date	4. COBRA Enrollment Period
	☐ Employment Separation/Time Base Reduction		
☐ New	☐ Divorce/Legal Separation		From _____ 01 _____
	☐ Child Ceases to be a Dependent		
☐ Change	☐ Death of an Employee		To _____
	☐ Dependent Eligibility Verification		
☐ Cancel	☐ Dependent Continuation – Original Enrollee Eligible for Medicare		
	☐ SSA Certified Disability – 11 Month Extension		

PART B: Enrollee Information

5. COBRA Enrollee (may be different from subscriber)

CalPERS ID or Social Security Number:

Name:

Address:

City, State, ZIP:

Primary Phone Number:

Married: ☐ Yes ☐ No

Date of Birth:

Gender: ☐ Male ☐ Female ☐ Non-Binary

PART C: Carrier Information

7. Name and Address of Health Plan: (Submit payment directly to the carrier)

Plan Code:

Premium: $

Phone Number:

6. CalPERS Subscriber/Member (Employee)

CalPERS ID or Social Security Number:

Subscriber Name:

Medical Group or CBU:

PART D: Dependent Information

ACTION CODE	8. List of all persons to be enrolled (including self): First / MI / Last / CalPERS ID or SSN / Date of Birth / Family Relationship / Medical / Dental
	First MI Last CalPERS ID or SSN Date of Birth Family Relationship: SELF Medical ☐ Dental ☐
	First MI Last CalPERS ID or SSN Date of Birth Family Relationship Medical ☐ Dental ☐
	First MI Last CalPERS ID or SSN Date of Birth Family Relationship Medical ☐ Dental ☐
	First MI Last CalPERS ID or SSN Date of Birth Family Relationship Medical ☐ Dental ☐

PART E: Enrollment Changes

9. Name of Prior Health Plan:	11. Type of Permitting Event:	12. Permitting Event Date:	13. Effective Date of Change:
10. Prior Plan Code:			01

PART F: Signature of Enrollee

14. I agree to pay the premium for the coverage directly to the carrier listed in Part C. I understand that I am required to send the initial payment prior to effective date of enrollment and agree to make future payments in a timely manner as required by the carrier. 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

PART G: Agency Information

15. Agency Name:

16. Health Benefits Officer's Signature:

Agency Code:

Date Received:

Phone:

Privacy Information

Submission of the requested information is mandatory. The information is collected pursuant to the Government Code Sections (20000 et. seq) and will be used for administration of the Board's duties under the California Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another government agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Security and Privacy Officer, CalPERS, 400 Q Street, Sacramento, CA 95811.

Instructions for the completion of the form HBD-85 (05/2021)

Part A

1. Type of Action
   a. Check "NEW" if this your new/initial enrollment
      i. Note: There cannot be a break in coverage between the end of CalPERS active health coverage and the beginning of COBRA enrollment
   b. Check "CHANGE" if you are adding or deleting dependents or for a plan change
   c. Check "CANCEL" if you are canceling your COBRA enrollment
      i. You can skip the rest of the sections in Part A
      ii. Complete Part B (5 & 6), Part E (13)
2. Check applicable Type of Permitting Event
3. Provide original Event Date (permanent separation, divorce date, etc.)
4. Enter original COBRA Enrollment Period
   a. Examples
      i. Permanent Separation date is 4/15/19 (COBRA Enrollment Period: From 6/1/2019 to 11/30/2020)
      ii. Child attains age 26 on 6/15/19 (COBRA Enrollment Period: From 7/1/2019 to 01/01/2021)

Part B

5. Provide all requested Information
6. Identify the employee if the COBRA enrollee is a former dependent

Part C

7. Identify the carrier. New COBRA enrollees may choose any carrier within their residential or work ZIP code area. Carrier changes are also allowed during the Open Enrollment period or due to a move. The health plan carrier's name, address, and phone number can be found in the annual Health Benefit Summary available in all employing agencies. COBRA premium payments are the responsibility of the COBRA enrollee and must be made directly to the carrier.

Part D

8. List all dependents to be enrolled, including self (if applicable)
   a. Use action code, "A" to indicate which dependent is being added (or newly enrolled)
   b. Use action code, "D" to indicate if a dependent is being deleted from an existing COBRA enrollment
   c. An Action Code is not required when changing carriers
   d. Select Health and/or Dental to indicate election based on Action Code

Important Note: The addition and deletion of dependents is regulated by time limits which are identical to those for active employees.

Part E

9. Name of Prior Health Plan (if changing carriers)

10-13. To be completed by the current or former agency's Health Benefits Officer/Personnel Office

Part F

14. Signature of COBRA enrollee and date signed

Part G

15-16. To be completed by the current or former employing agency's Health Benefits Officer/Personnel Office. CalPERS is the "employing agency" for former dependents 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 the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.

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 is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be.
Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

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

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

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, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).