RISK MANAGEMENT
**DEANNA L. ZALAS**
DIRECTOR
118 N. Clark Street, #1072 ● Chicago, Illinois 60602 ● (312) 603-6385



## COBRA ELECTION NOTICE

Date:

Name
Address
City, State Zip Code

THE FOLLOWING INFORMATION MUST BE SHARED WITH EACH OF YOUR COVERED DEPENDENTS WHOSE COVERAGE IS BEING TERMINATED:

Your coverage under the County of Cook Employee Health Plans will terminate effective _____. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that qualified beneficiaries (employees and/or covered dependents) have the option of continuing group health care, dental, vision and FSA benefits if coverage ended because of the following reasons:

| | |
|---|---|
| 1. Voluntary or involuntary termination of Cook County Employment for reasons other than gross misconduct | Eligible 18 months |
| 2. Reductions of employee's working hours | Eligible 18 months |
| 3. Death of covered employee | Dependents Eligible 36 months |
| 4. Divorce or legal separation of covered Employee (In order to be eligible for COBRA the employee or spouse must notify the Employee Benefits Office within 60 days of the event) | Dependents Eligible 36 months |
| 5. Loss of "dependent child" status under plan rules | Dependents Eligible 36 months |

*If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of termination-or within the first 60 days of COBRA coverage-and he/she notifies the plan administrator within 60 days of the disability determination, the 18 month period is extended to 29 months.

If you or any of your covered dependents decide to continue your current benefits under COBRA, it will become effective immediately upon termination of our current coverage.

**TO ENROLL, FOLLOW THE STEPS BELOW:**

1. Inform the Employee Benefits Office within 60 days from the date of termination of coverage that you wish to continue your current health insurance benefits.
2. The person applying for COBRA, not necessarily the employee must complete a "Benefits Enrollment/Change Form" and return it to the Employee Benefits Office.
3. Send your first month's premium payment to the Employee Benefits Office. This premium must be received no later than 45 days from the date you elect COBRA (the date the form is received by the Employee Benefits Office). It is recommended that the first payment accompany your enrollment form(s).

**Premiums are due by the first of each month.**
**Failure to make a required premium will result in cancellation of benefits.**

Payments in the form of a Cashier's Check, Money Order, or Certified Check ONLY should be made payable to:

**COOK COUNTY DEPARTMENT OF REVENUE**

Mail premiums to:
**COOK COUNTY DEPARTMENT OF REVENUE COLLECTIONS DIVISION**
**118 N. CLARK ST. SUITE 1160**
**CHICAGO, ILLINOIS 60602**

Credit/debit card payments can be made via phone or online.

Phone payments:
Call: 888-497-8701
Provider ID# 58840

Online payments:
https://payments.lexisnexis.com/IL/Cook/Insurance

CONTINUATION OF FLEXIBLE SPENDING (FSA) – Contact Employee Benefits Office 312- 603-6385

COBRA benefits will be terminated under the following conditions:

1. The last day of eligibility has been reached. (Upon expiration of coverage under COBRA you will be allowed to enroll in an individual Conversion health plan directly with your health plan)
2. Non-payment of premium. In compliance with Federal Legislation, payments post- marked more than 30 days after the premium due date will not be accepted. They will be returned and your COBRA cancelled.
3. Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation to any pre-existing condition of the beneficiary.
4. A beneficiary is entitled to Medicare.