SAMPLE Model **N.J. Continuation** Coverage Election Notice

(Send to the employee immediately upon the qualifying event or loss of coverage date along with the carrier specific enrollment form via 1st class mail). Optional: You may but are not obligated to obtain a Certificate of Mailing at any post office to prove you mailed the notice.

Date: (Enter the date of the notice)

Dear: (Identify the qualified beneficiary by name)

This notice contains important information about your right to continue your health care coverage (ONLY Horizon BCBSNJ allows dental to be continued) with (enter the group health plan carrier name). Please read this notice very carefully.

To elect N.J. Continuation coverage, complete the attached (Carrier) Election Form and this document and submit them to us no later than 30 days from your loss of coverage date. If we do not hear from you your coverage will end (enter the last date of coverage) and it cannot be reinstated.

Premium **retroactive** to the loss of coverage date is due to us NO later than 30 days from the date you mail this election form back to us.

The **monthly c**ost for your continued coverage is (enter the full premium plus the permitted 2% administrative charge) $_____. The full retroactive amount must be returned to us along with the fully completed and signed application form as stated above. If your dependents do not wish to continue, please call this office for the appropriate premium due to continue for yourself alone.

Each covered person in your family is eligible to continue with you.
If your coverage is ending due to termination of employment or a reduction of hours whereby you are no longer eligible for the health plan, you and any covered family member(s) may continue for 18 months.
Coverage may be extended to 29 months if you are declared Medicare disabled retroactively to a date within 60 days of first becoming eligible for continuation.
During this extension we are permitted to charge 150% of the full premium.
Your covered spouse and any covered dependents will be able to continue for 36 months in the event of your death or divorce .
A child(ren) who loses coverage because s/he is no longer eligible as a dependent may continue up to 36 months.

You may contact me at _____ for further information.

_____Signature _____Title

This information should not be used as a substitute for consultation with professional accounting, tax, legal or other competent advisers.