COBRA ELECTION NOTICE

Date of Notice: DATE

NAME
ADDRESS
CITY STATE ZIP

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

This notice contains important information about your right to continue your vision coverage with Vision Service Plan. Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to VSP.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on DATE.

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue vision coverage under the Plan for up to months.

- ☐ Employee or former employee
- ☐ Death of employee
- ☐ Spouse or former spouse
- ☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on **DATE** and can last until **DATE**.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including Vision Service Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group vision plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group vision plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, or
- the employer ceases to provide any group vision plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Vision Service Plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. COBRA enrollee must submit to VSP a copy of the Social Security Award letter, or equivalent proof of disability. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. 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 only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group vision coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group vision plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual vision insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group vision plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group vision coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice

When and how must payment for COBRA continuation coverage be made?

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not 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 not later than 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. You may contact Vision Service Plan to confirm the correct amount of your first payment.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

VSP COBRA ENROLLMENT

GROUP NAME: **Automotive Aftermarket 30062163-0003**	**Date Coverage Begins:**	**Date of Qualifying Event:**

DESCRIPTION OF QUALIFYING EVENT:

☐ Disabled on the date of qualifying event	☐ Reduction of hours
☐ Legal separation or divorce	☐ Retiree
☐ Leave of absence – Dates from _____ to _____	☐ Surviving Dependents
☐ Loss of child's dependent status	☐ Termination of employment

COBRA APPLICANT INFORMATION:

Name of COBRA Applicant (Last, First, Middle Initial)	Daytime Telephone Number ( )	Sex ❑ Male ❑ Female
Mailing Address (Number, Street, City, State, ZIP)		
Social Security Number	Birth Date (Month/Day/Year)	Marital Status ❑ Married ❑ Single

CURRENT/FORMER EMPLOYEE INFORMATION:

Name of Employee	Social Security Number of Employee	Relationship to Applicant

ELIGIBLE FAMILY MEMBERS (List dependents to be enrolled. Attach separate listing if more dependents exist.):

Name (Last, First, Middle Initial):	Social Security Number:	Birth Date (Month/Day/Year)	Sex	Relationship to Employee
			❑ Male ❑ Female	
			❑ Male ❑ Female	
			❑ Male ❑ Female	
			❑ Male ❑ Female	

ELIGIBILITY PERIODS:

The Consolidated Omnibus Budget Reconciliation Act (**COBRA**) allows an employee whose group insurance terminates due to reduction of work hours or termination of employment - for reasons other than gross misconduct - to continue their insurance coverage for themselves for **up to 18 months**. Surviving dependents, divorced or legally separated spouses and dependents, and children who lose coverage due to age or marriage may continue their coverage for **up to 36 months**. COBRA allows temporary extension of benefits only.

PAYMENT REQUIREMENTS:

To continue vision coverage through Vision Service Plan (VSP), monthly premium must be received by the 1st of each month . (i.e., April premium must be received by April 1st). Failure to pay premiums will result in the termination of coverage.

ELECTING CONTINUATION OF VISION CARE COVERAGE:

This form must be mailed to Vision Service Plan within 60 days from the date it was received by the COBRA applicant to elect continuation of vision care coverage. After 60 days, the election period ends and eligibility ceases.

PAYMENT AGREEMENT:

- ❑ I elect to continue vision coverage at a rate of $ _____ per month. Premium may increase with employer's rate.
- ❑ Enclosed is my check for _____ months of coverage.
- ❑ My check for at least one month's premium will follow within 45 days of VSP's receipt of this form. Check will be applied RETROACTIVELY to effective date of coverage.

NOTIFICATION AGREEMENT and SIGNATURES (Parent or Legal Guardian must sign if dependents are minor children):

Signature of COBRA Applicant:	Date:

RETURN COMPLETED FORM TO: Automotive Aftermarket Association Southeast, Inc.
11245 Chantilly Parkway Court, Montgomery, AL 36117 ATTN: Kay McCoy

Member Only = $ 6.09 Member + Spouse/DP = $ 12.20 Member + Children = $ 13.05 Member + Family = $ 20.86

COBRA ELECTION FORM
Vision Program

PRIVACY NOTICE

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by VSP and the Department of Personnel Administration for the purpose of identification and vision coverage processing.

It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in the vision enrollment action not being processed or being processed incorrectly.

The Department of Personnel Administration requires social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151, 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on this form will be maintained by the vision company providing coverage. Copies of the COBRA Election Form are maintained in confidential files of the Vision Service Plan for five years. Individuals have the right of access to copies of their COBRA Election Form upon request. Send requests to: Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899-7100, Attention: COBRA Unit