Employee Election Form – California COBRA

*Required Field

The California Continuation Benefits Replacement Act allows small employers (with 2 to 19 employees on at least 50% of its working days during the preceding calendar year) in California to offer continued coverage to employees and their dependents that lose coverage through qualifying events.

Employee: You are eligible to continue your coverage for yourself and/or your dependents currently enrolled.

Please return the completed form to the address below within 60 days following the later of (1) the date of the qualifying event; (2) the date you were provided notification of the election to continue coverage; or (3) the date coverage under the insurance plan terminates. Failure to provide this completed form within the required 60 days will disqualify you from receiving continuation coverage.

Address: Sun Life Financial
Sun Life Administrative Office
P.O. Box 981624
El Paso, TX 79998-1624
Fax: 888.208.2323

Check the coverages you wish to continue: *

☐ Dental ☐ Vision ☐ Critical Illness ☐ Gap
☐ Cancer ☐ Employee Assistance Program

Employer Name * ______________________ Policy no. * ______________

Employer address ______________________________________

Name of Covered Employee * ______________________ Certificate no. ______________

Date of Qualifying Event* ______________________ Date Coverage Terminated * ______________

Date qualified individual was notified of California COBRA rights* ______________________

Qualifying Events *(Please check the appropriate box.)* *

☐ Termination of employment (except gross misconduct) or reduction in hours of the covered employee's employment

☐ Divorce or legal separation of the covered employee from the covered employee's spouse

☐ Loss of dependent status by a dependent enrolled in the group benefit plan

☐ For a covered dependent only, the covered employee's entitlement to Medicare

☐ Death of covered employee

☐ Occurrence of a second qualifying event. Explain ______________________

California COBRA benefits will be terminated if premiums are not paid in a timely manner or if other group coverages are obtained.

Employer's signature ______________________________ Date ______________

If you or your dependents obtain or are already covered under another group plan (that does not exclude or limit coverage for pre-existing conditions) after the date continuation of coverage has been elected, then COBRA continuation will terminate as of the effective date of the other group plan.

Please print.

Group name *		Policy no. *
Participation no.	Account no.	Certificate no.
Employee name *		
Employee's address—Street * City State Zip		

List all qualified individuals to be covered under the continuation and list the coverages to be continued. *(Any qualified individuals that are not listed will not be insured for continuation of coverage.)* Only those coverages that were in effect immediately prior to the date coverage terminated, can be continued. Use a separate sheet of paper if additional space is needed; sign and attach extra copies.

Qualified Individuals	Social Security No.	Date of Birth	Coverage(s)
Employee's name			
Spouse's name			
Dependent's name			
Dependent's name			

Are you or your dependents covered under another group plan? ☐ Yes ☐ No

If "Yes," name of insurance company ______________________ Effective date ______________

IMPORTANT! PLEASE SIGN

☐ I am electing to continue coverage as indicated above for those persons named. I understand that it is my obligation to pay all premiums when due in order to secure and maintain continuation of coverage.

I also agree to notify the employer if I or my dependents become covered under another group plan.

SIGNATURE DATE

☐ I am waiving my rights to continue all coverage for myself and/or my eligible dependents and do NOT wish to elect continuation of coverage.

If all coverage is being waived for employee and/or dependents, the employee and each adult *(18 or over)* dependent MUST sign the form.

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

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