SBG
Sax Benefits Group, Inc.

MR SAMUEL SMITH
4005 SUN VALLEY DRIVE
ST LOUIS MO 63141

**Model COBRA Continuation Coverage Election Notice**

Notice Date: 09/04/2009

Dear Mr Smith:

**This notice contains important information about your right to continue your health care coverage in the Plan(s).**
Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

To elect COBRA continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on 09/03/2009 due to your COBRA-ARRA:

Each of the following dependents, if any are entitled to elect to continue health care coverage under the Plan:

Because of the above event that will end your coverage under the Plan, you and/or, any of your dependents who were covered on the day before the event are entitled to continue your health coverage for up to 18 months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on 09/04/2009 and can last until 03/04/2011.

Your continuation coverage will cost without the Subsidy:

| Coverage | Amount Due | Election Expires | Date | Net Due |
|---|---|---|---|---|
| Dental Contract - Indiv | $ 28.56 | 11/02/2009 | 09/04/2009 | $ 28.56 |
| Health Employee | $ 397.80 | 11/02/2009 | 09/04/2009 | $ 397.80 |
| Vision - Individual | $ 12.24 | 11/02/2009 | 09/04/2009 | $ 12.24 |
| | $ 438.60 | | | $ 438.60 |

If you qualify as an "Assistance Eligible Individual" this cost will be referenced below for up to nine months.

| Carrier Name | Description | Amount Due | Bill.Cycle |
|---|---|---|---|
| Delta Dental | Dental Contract - Indiv | $ 10.00 | 1 Month |
| HealthLink Open Access 1 | Health Employee | $ 139.23 | 1 Month |
| VSP Vision Service Plan | Vision - Individual | $ 4.28 | 1 Month |

After the nine months is up, your costs will be:

| Carrier Name | Description | Amount Due | Bill.Cycle |
|---|---|---|---|
| Delta Dental | Dental Contract - Indiv | $ 28.56 | 1 Month |
| HealthLink Open Access 1 | Health Employee | $ 397.80 | 1 Month |
| VSP Vision Service Plan | Vision - Individual | $ 12.24 | 1 Month |

You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.
If elected, COBRA continuation coverage will begin on 09/04/2009 and can last until 03/04/2011

**IMPORTANT - To elect continuation coverage you MUST complete the "Election Form" and return it to us. You may mail it to the address shown on the Election Form. 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.**

**The completed Election Form must be post-marked by 11/02/2009. If you do not submit a completed Election Form by this date, you will lose your right to elect 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. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.**

**Important information about your rights is provided to you on the pages after this Election Form. If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact:**

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

Samuel Smith
Qualification Date: 09/04/2009

# COBRA CONTINUATION COVERAGE ELECTION FORM

## ELECTING COVERAGE

Each eligible family member may elect coverage independently by completing a separate copy of this ELECTION AGREEMENT. The primary qualified beneficiary may elect to continue coverage on behalf of all eligible dependents who were covered the day before the qualifying event, but only a dependent or legal guardian may elect or decline coverage which the primary qualified beneficiary has declined.

If any family member declines any coverage, please complete the section titled DECLINING COVERAGE. Your completed ELECTION AGREEMENT must be returned by 11/02/2009 or you will lose your right to COBRA continuation coverage.

I elect the coverage(s) that I have checked below for myself and my eligible dependents, if any:

| | Carrier Name | Description | Bill.Cycle | Amount Due |
|---|---|---|---|---|
| ☐ | Delta Dental | Dental Contract - Indiv | 1 Month | $ 10.00 |
| ☐ | HealthLink Open Access 1 | Health Employee | 1 Month | $ 139.23 |
| ☐ | VSP Vision Service Plan | Vision - Individual | 1 Month | $ 4.28 |

You must provide the information below for any dependent not shown who will be covered. Complete any missing information for any dependents listed below.

| **Last Name, First** | **Birthdate** | **Gender** | **Relationship** | **Dependents SSN** |
|---|---|---|---|---|
| _____ | ___/___/___ | _____ | _____ | ____-____-_____ |
| _____ | ___/___/___ | _____ | _____ | ____-____-_____ |
| _____ | ___/___/___ | _____ | _____ | ____-____-_____ |

I have read the NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE and understand my election rights. I agree to notify the Plan Administrator if I or any covered dependents become covered by another group health plan or entitled to Medicare or have a change of address.

_____ _____
Signature Date

( )
_____
Phone Number

Samuel Smith
Qualification Date: 09/04/2009

**ELECTION AGREEMENT**

(continued)

**DECLINING COVERAGE**

Each family member who was covered on the day before the event who does not wish to elect COBRA continuation coverage must sign and date the DECLINATION STATEMENT below. A legal guardian may sign on behalf of a minor child.

I have read the NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE and understand my election rights. I understand that a gap of 63 days in coverage will affect my ability to obtain coverage for pre-existing conditions under another Plan according to the portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I decline all coverage(s) not elected in the ELECTING COVERAGE section. I understand that this declination will be irrevocable after my Election End Date of 11/02/2009. Further, I understand that I may revoke this waiver at any time prior to my Election End Date, however the effective date of coverage would be the date that I revoke the waiver.

| _____ | _____ | _____ |
|---|---|---|
| PRINT NAME | SIGNATURE | DATE |
| _____ | _____ | _____ |
| PRINT NAME | SIGNATURE | DATE |
| _____ | _____ | _____ |
| PRINT NAME | SIGNATURE | DATE |
| _____ | _____ | _____ |
| PRINT NAME | SIGNATURE | DATE |

For further information, please contact:

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

# Important Information About Your COBRA Continuation Coverage Rights

**What is continuation coverage?**

Federal law requires that most group health plans (including this 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 health 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, including open enrollment special enrollment rights.

**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 first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health 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 Sax Benefits Group, Inc.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 under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. 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 to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that 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 legal 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 health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect 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 health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health 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.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

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

*First payment for continuation coverage*

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 Sax Benefits Group, Inc.to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

*Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.The Plan will send periodic notices of payments due for these coverage periods.

*Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day

of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to:

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

**For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at **www.dol.gov/ebsa** State and local government employees should contact HHS-CMS at **www.cms.hhs.gov/COBRAContinuationofCov/** or **NewCobraRights@cms.hhs.gov**

**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.

# Summary of the COBRA Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

**Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.**

**IMPORTANT**

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.

- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov

For general information regarding your plan's COBRA coverage or specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums,
Please Contact,

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:
**www.dol.gov/COBRA o**r call 1-866-444-EBSA (3272)

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

# REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Instructions

To apply for ARRA Premium Reduction, complete this form and return it to us along with your Election Form.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."
You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to the contact information found under *Additional Election Period* section.

## Personal Information

Name: Mr Samuel Smith Telephone: _____-_____-_____

Address: 4005 Sun Valley Drive
St. Louis, MO 63141 Email (Optional): _____

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To Qualify, you must be able to check 'Yes' for all the statments*

| | |
|---|---|
| **1. The loss of employment was involuntary.** | [ ] **Yes** [ ] **No** |
| **2. The loss of employment occured at some point on or after September 1, 2008 and on or before December 31, 2009.** | [ ] **Yes** [ ] **No** |
| **3. I elected (or am electing) COBRA continuation Coverage*** | [ ] **Yes** [ ] **No** |
| **4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).** | [ ] **Yes** [ ] **No** |
| **5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).** | [ ] **Yes** [ ] **No** |

** If you circled NO for statement 3, you may still be eligible. See below for more information.*

***ADDITIONAL ELECTION PERIOD***

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form which you MUST complete and return. If you believe you should have received this additional notice but have not, contact

SBG - COBRA Department
10825 Watson Road, Suite 160
St. Louis, MO 63127
Customer Service (314) 822-6100 ext 2300
Email: COBRA@sbgstl.com

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I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I provided on this form are true and correct.

_____ _____ _____
PRINT NAME SIGNATURE DATE

**FOR EMPLOYER OR PLAN USE ONLY**

This application is: □Approved □Denied □Approved for some/denied for others (explain in #4 below)

**Specify reason below and then return a copy of this form to the applicant.**

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

| | |
|---|---|
| **1. Loss of employment was voluntary** | **[ ]** |
| **2. The inoluntary loss did not occur between September 1,2008 and December 31,2009** | **[ ]** |
| **3. Individual did not elect COBRA coverage.*** | **[ ]** |
| 4. Other (please explain on reverse side) | [ ] |

**If you checked number 3, was individual eligible for, and given, the Additional Election Period described on reverse side?*

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

_____ _____ _____
PRINT NAME SIGNATURE DATE
Telephone number_____ E-mail address _____

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

| **Last Name, First** | **Birthdate** | **Gender** | **Relationship** | **Dependents SSN** |
|---|---|---|---|---|
| _____ | ___/___/___ | _____ | _____ | ____-____-_____ |

**1. I elected (or am electing) COBRA continuation coverage.** [ ] Yes [ ] No
**2. I am NOT eligible for other group health plan coverage.** [ ] Yes [ ] No
**3. I am NOT eligible for Medicare.** [ ] Yes [ ] No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

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| **Last Name, First** | **Birthdate** | **Gender** | **Relationship** | **Dependents SSN** |
|---|---|---|---|---|
| _____ | ___/___/___ | _____ | _____ | ____-____-_____ |

**1. I elected (or am electing) COBRA continuation coverage.** [ ] Yes [ ] No
**2. I am NOT eligible for other group health plan coverage.** [ ] Yes [ ] No
**3. I am NOT eligible for Medicare.** [ ] Yes [ ] No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

---

| **Last Name, First** | **Birthdate** | **Gender** | **Relationship** | **Dependents SSN** |
|---|---|---|---|---|
| _____ | ___/___/___ | _____ | _____ | ____-____-_____ |

**1. I elected (or am electing) COBRA continuation coverage.** [ ] Yes [ ] No
**2. I am NOT eligible for other group health plan coverage.** [ ] Yes [ ] No
**3. I am NOT eligible for Medicare.** [ ] Yes [ ] No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

# Participant Notification

**Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.**

## Personal Information

Name: Mr Samuel Smith Telephone: _____-_____-_____

Address: 4005 Sun Valley Drive
St. Louis, MO 63141 Email (Optional): _____

## PREMIUM REDUCTION INELIGIBILITY INFORMATION - Check one

I am eligible for coverage under another group health plan. ☐
If any dependents are also eligible, include their names below.

Insert date you became eligible_____

I am eligible for Medicare. ☐
Insert date you became eligible_____

## IMPORTANT

**If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.**

**Eligibility is determined regardless of whether you take or decline the other coverage.**

**However, eligibility for coverage does not include any time spent in a waiting period.**

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature _____ Date _____

Type or print name _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____