

**(Only applicable to groups subject to Federal COBRA)**

**Note:** Complete this Contract if you would like to be billed for COBRA participants.

I, \_\_\_\_\_, am an authorized representative of \_\_\_\_\_.

(Print Name)

(Print Group/Company Name)

The group listed above requests that information (including premiums due) intended for all COBRA participants under Federal COBRA regulations be sent directly to the group to be forwarded to the COBRA participants.

The group will ensure that the information they receive from HSA California®, intended for COBRA participants, is forwarded to the COBRA participants in a timely manner and with complete instructions.

**Please initial each section:**

\_\_\_\_\_ The group understands that HSA California must receive written notification to **cancel coverage** for an **employee** within **30 days** of an employee event in order to give the group full credit for the employee cancellation (i.e. an employee termination, reduction of hours or death).

\_\_\_\_\_ The group understands that HSA California must receive written notification to **cancel coverage** for an **employee's dependent** within **65 days** of a dependent qualifying event in order to cancel coverage based on the qualifying event (i.e. divorce, employee's Medicare entitlement or loss of dependent child status). All notification received beyond 65 days will be processed as a voluntary cancellation of coverage.

\_\_\_\_\_ The group understands that HSA California must receive **COBRA elections** no later than **5 business days** from the end of the qualified beneficiary's election period. Elections must be sent to HSA California, Attn: COBRA, 721 South Parker, Suite 200, Orange, CA 92868.

\_\_\_\_\_ The group understands that HSA California must receive **requests** (i.e. elections, changes, etc.) **within specified guidelines** in order to be processed. *(Please refer to the group service contract or the Administrative Handbook for guideline information.)*

\_\_\_\_\_ The group understands that HSA California will directly bill the group on the group's monthly invoice statement for each COBRA participant who falls under Federal COBRA regulations. The premiums must be paid as billed by the due date indicated on each invoice statement, regardless of payment made by the COBRA participant to the employer group or the employer group's third-party administrator.

\_\_\_\_\_ The group understands that each COBRA participant will have the same open enrollment period as the group. The group will be responsible for forwarding open enrollment materials to each COBRA participant and notifying them of the deadline for return of the materials.

\_\_\_\_\_ The group understands that each request for cancellation of COBRA continuation coverage must be received in writing no later than **45 days** after the effective date of the cancellation, even if no **refund\*** of premiums will result from the cancellation request.

**\*Note:** A refund will only be given if HSA California receives a written request for cancellation by the 15th of the month following the month for which the request is being made. (i.e. A refund for May premium can only be issued if a written request is received by June 15th.)

By initialing all sections above and signing this contract I acknowledge that the group understands and agrees to the terms listed above. This contract will take effect with the next processed invoice statement following the receipt of a fully executed contract.

This contract will expire when the employer group's coverage cancels with HSA California, when the employer group is no longer subject to Federal COBRA or when HSA California processes a written request to cancel direct billing as submitted by the group.

**Printed Name of Authorized Representative:** \_\_\_\_\_

**Signature of Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Group Number: \_\_\_\_\_