Cobra Notification Guidelines

This material is designed to provide guidance to departments responsible for COBRA notification.

General COBRA Information

1. The consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives employees and dependents the option to extend group health/dental/vision coverage in some situations in which coverage ordinarily would end.

2. COBRA qualifying events include:
   - Terminations
   - Transfer to a position ineligible for benefits
   - Reduction in effort below 50%
   - Leave without pay
   - Employee's divorce
   - Child reaching maximum age allowance
     - Age 25 – dental and vision coverage
     - Age 26 – health coverage
   - Child marries (for dental and vision coverage)
   - Employee's death

3. A qualified beneficiary for COBRA purposes is any person who, on the day before the qualifying event, is covered under a group health/dental/vision plan maintained by Texas A&M University and is either a covered employee, the spouse of a covered employee, or an eligible dependent child or grandchild of a covered employee.

4. The COBRA Form informs each qualified beneficiary that they have the right to continue their group health and/or dental and/or vision insurance coverage under COBRA.

5. The COBRA election period is 60 days and begins on the day following the qualifying event or the date of the notice of COBRA eligibility, whichever is later.

6. Each qualified beneficiary must be offered the right to make an independent COBRA election. However, the covered employee may make a positive election to remain on the coverage for all eligible dependents. If the covered employee elects to discontinue the coverage, any of the qualified beneficiaries may make an independent election within the 60-day election period.

7. COBRA participants are entitled to the same health/dental/vision options and are subject to the same guidelines for making changes as a regular employee.

8. COBRA premium rates are 2% higher than the full cost of active employees, and COBRA participants are not eligible for the state contribution.

9. If a COBRA participant drops or cancels coverage at any time during the COBRA period, insurance coverage under COBRA cannot be reinstated.
Processing Guidelines for COBRA Qualifying Events

The COBRA Form is found online here.

Employee Terminations (COBRA Provided by Benefits Services)

1. The employing department completes a request for an Employee Payroll Action (EPA) for termination and electronically submits to Payroll Services for processing.

   The EPA terminating the employee must be completely routed and approved in the department at least five working days prior to the end of the month in which the employee terminates to ensure that the health insurance coverage is canceled in a timely manner.

2. Payroll Services and Human Resources enters the EPA termination request into the (B/P/P) Budget, Payroll and Personnel system which electronically generates the COBRA Form for the terminating employee.

3. After the COBRA Form has been generated by BPP for the terminating employee, the form is downloaded into the HRConnect System and automatically scanned into the HR Insurance Benefit document file. Benefits Services mails the COBRA Form to the employee’s last known mailing address.

Loss of Benefits Eligibility - Employment Changes (COBRA provided by the Department) Includes transfers to a position ineligible for benefits, reduction in effort or leave without pay.

1. The employing department completes a request for an EPA and submits to Payroll Services for processing. The EPA transferring the employee into an ineligible benefit position, reducing the employee’s percent effort below 50% or placing the employee in a leave without pay status must be completely routed and approved in the department at least five working days prior to the end of the month in which the qualifying event occurs.

   The EPA document and the COBRA Form should be completed and submitted to the appropriate areas of responsibility simultaneously (EPA – goes to payroll and a copy of the COBRA Form goes to Benefits Services)

2. A COBRA form must be provided in person or by first class mail within 14 days of the date the employing department learns of the qualifying event.

3. A COBRA Form sent by mail should be addressed to the employee’s last known address. A separate form must be mailed to any dependent known to be living outside the employee’s residence. Complete the U.S Postal Service Certificate of Mailing (PS form 3817) which provides proof that the notice was mailed (See Attachment A).

   ✔ Place a copy of the completed COBRA Form and the post marked Certificate of Mailing Label in the employees personnel file.

4. A COBRA Form provided to the employee in person should be accompanied the COBRA Information Acknowledgment Form (See Attachment B) to be signed by the employee.

   ✔ Place a copy of the Cobra Form and a copy of the Information Acknowledgment Form in the employees official personnel file.
Loss of Benefits Eligibility - Family Status Changes (COBRA provided by Benefits Services)  
Includes divorce, death and loss of dependent child eligibility because of reaching maximum age or marriage.

1. The employee is responsible for notifying Benefits Services within 60 days of the qualifying event impacting dependent eligibility and to complete the appropriate dependent enrollment certification form. (Exception: Maximum age notifications will be produced directly by the BPP System and provided to Benefit Services).

2. Benefits Services completes and mails the COBRA Form to the qualified Beneficiary within 14 days of notification of the qualifying event.

References
Please refer to the following System Policies (SP), System Regulations (SR) and University Rules (UR) for information regarding COBRA.

- Group Insurance Programs (SR 31.02.02)
- Employee Insurance and Retirement Benefits (SP 31.02)
- Leave of Absence Without Pay (SR 31.03.04 and SAP 31.03.04.M0.01)
- Family Medical Leave Act – SR 31.03.05

If you have questions, please contact Benefits Services at benefits@tamu.edu or 979-862-1718.
Attachment A

Certificate of Mailing Label (PS 3817)

The certificate of mailing form is used when proof of mailing is required. The certificate of mailing label (PS 3817) may be obtained from the University Mail Service free of charge. However, you are required to pay the postage and mailing fee which are considerably less expensive than certified mail postage.

Instructions for completing a certificate of mailing label:

The upper portion of the certificate of mailing should include the mailing address of the department.

Example: Human Resources Benefits Services
Texas A&M University
MS1255
College Station, Texas 77843-1255

The lower portion of the certificate of mailing label should include the employee’s last known address.

Example: Ms. John Doe
1123 West Street
USA 77777

After addressing the certificate of mailing label, affix the certificate to the left side of the addressed envelope and place in regular mail. The post office will postmark the certificate of mailing label and return it to you. Once you have received the postmarked certificate of mailing label, staple it to your copy of the notification of continuation coverage form in the employee’s official personnel file. This will serve as proof that the notification was mailed.
Attachment B

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received the **Health/Dental/Vision Coverage Continuation Form** from my employing department. I further understand that each of my eligible dependents (qualified beneficiaries) currently enrolled under my insurance plan has the right to continue their group health/dental/vision insurance coverage.

I also understand that I have the right to make a positive election to remain on the coverage for all eligible dependents. However, if I elect to discontinue my insurance coverage, any of the eligible dependents may make an independent election within the 60-day election period.

____________________________________________________
Employee Signature

____________________________________________________
Print Employee Name

____________________________________________________
Employee’s Universal Identification Number (UIN)

________________________
Today’s Date

*The original acknowledgment is filed in the department and a copy is given to the employee.*