

Attention Group Administrator — Cal-COBRA (SB 719) is Effective January 1, 1998!

Cal-COBRA provides for continuation of coverage similar to Federal COBRA for Groups of 2-19 employees, on condition that the number of employees remains at 2-19 for at least 50% of the previous calendar year.

- < Cal-COBRA applies ONLY to Groups of 2-19 employees.
- < Groups of 20 or more employees are eligible ONLY for Federal COBRA, not Cal-COBRA.
- < Groups of 1 employee are not eligible for EITHER program.

The Cal-COBRA Administrator will administer Continuation of Coverage to eligible Subscribers based on the following criteria:

1. **The Qualifying Events for Subscriber eligibility in the program are:**
 - < Death of the plan Subscriber;
 - < Subscriber's termination of employment or reduction of work hours;
 - < Spouse's divorce or legal separation from the Subscriber;
 - < Loss of eligible Dependent status of an enrolled Dependent Child; or
 - < If an employee is an enrolled Dependent, the Subscriber becomes eligible for Medicare.
2. **Notification of a Qualifying Event to The Cal-COBRA Administrator is the *Subscriber's responsibility*, EXCEPT that the Group must notify the Cal-COBRA Administrator in the event of the termination of employment, or the reduction of work hours, within 31 days. The Cal-COBRA Administrator must be notified of the occurrence of any of the other qualifying events by the Subscriber within 60 days of the event. All notifications of qualifying events must be submitted to the Cal-COBRA Administrator in writing.**
3. **Within 14 Days of Notification to the Cal-COBRA Administrator of a qualifying event, the Subscriber will receive notice from the Cal-COBRA Administrator regarding enrollment and premium for the continuation of coverage.**
4. **Continuation of Coverage is the same coverage in effect at the time of the Subscriber's qualifying event and subject to any subsequent changes to that coverage. If dental coverage is currently included, the Subscriber will have the option to continue medical and dental, or medical only. Dental-only continuation coverage is not offered.**
5. **Premium Payment on a monthly basis is the responsibility of the Subscriber. Failure to pay the premium within the prescribed payment due deadlines will constitute discontinuation of coverage with no option of reinstatement.**

Any Subscriber electing Cal-COBRA continuation coverage will be billed separately for the premium, beginning 1/1/98.

**Questions? Call Banyan Administrators, LLC
Managers, for the CalCPA ProtectPlus Programs
(877) 480-7923**

**Employer Notification Form
to the Group Insurance Trust
of the California Society of Certified Public Accountants
of a COBRA or Cal-COBRA Qualifying Event**

General Instructions:

The state Cal-COBRA legislation became effective January 1, 1998. Complete and fax or mail this form within 31 days following the date of the qualifying event.

Employer Information:

Name of Employer: _____

Address of Employer: _____

Number of Employees on Date of Qualifying Event: _____

Name and Phone Number of Employer Primary Contact to Call for Additional Information:
_____ (____) _____

Covered Employee/Qualified Beneficiary Information: _____

Name of Covered Employee: _____

Name of Other Qualified Beneficiary (ies): _____

Spouse: _____

Dependent 1: _____

Dependent 2: _____

Dependent 3: _____

(Please list additional dependents on a separate sheet and attach it to this form.)

Current Address of Covered Employee, and if different, Other Qualified Beneficiaries:

Qualifying Event Information:

The Qualifying Event Was:

- The death of a plan participant.
- The termination or reduction of hours of a plan participant's employment.
- The divorce or legal separation of a plan participant from the plan participant's spouse.
- The loss of dependent status by a child of a plan participant enrolled in the plan.
- With respect to a dependent only, the plan participant's eligibility for coverage under Medicare.

The date of the Qualifying Event was: _____ / _____ / _____
(mm/dd/yy)

The termination of employment was: ____ Voluntary ____ Involuntary

Notification Instructions:

Complete this notification form within 31 days following the date of the Qualifying Event and fax to (877) 237-4519 or send to:

**Banyan Administrators, LLC
Managers for the CalCPA ProtectPlus Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Phone: (877) 480-7923
Fax: (877) 237-4519**