

COBRA QUALIFYING EVENT FORM Instructions

Enclosed please find a COBRA Qualifying Event Form to submit to our office when an employee terminates, has a reduction in hours, or experiences any of the qualifying events listed on the form. As a reminder, please note that gross misconduct, as described on the form, renders the employee ineligible for COBRA benefits. **Be aware that the filing period for this form is within 30 days from the qualifying event.**

COBRA coverage is available for employers that have at least 20 employees for at least 6 months in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

We will send your terminated employee a COBRA Notice and Election Form including explanation of rates, payment instructions, time period for election (60 days) once we receive the COBRA Qualifying Event Form from you.

Federal Law allows for a Qualified Beneficiary who had waived his/her right to COBRA coverage during the election period the right to revoke the waiver of coverage as long as it is done before the end of the election period.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To continue coverage through COBRA, members must submit the initial payment to HMAA along with the election form within 60 days of loss of coverage or receipt of COBRA Notice and Election Form, and continue remitting full COBRA premium payment to HMAA until the end of his/her COBRA coverage period.

Please fax the Qualifying Event Form to **(808) 535-8353** (you do not need to mail the original, but please keep the fax confirmation for your records), or mail it to our office:

HMAA
Attn: Billing & Member Services
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Please feel free to contact our Customer Service Center at 941-4622, toll-free at (888) 941-4622 or via e-mail at CustomerService@hmaa.com if you have any questions.

**COBRA QUALIFYING EVENT FORM
(NOTICE FROM EMPLOYER)**

COBRA coverage is not available to companies that did not have 20 or more employees for at least 6 months (50% of the year) in the preceding calendar year.

Note: Previous versions of this form are not accepted.

Date: _____

To: **HMAA**

From: _____
Group Name Group No.

Re: _____
Name of Employee

_____ Member ID Number Home Phone Number

_____ Home Address *

_____ City State Zip Code

* We will not accept this form without the employee's last known address.

This is to inform the Plan Administrator of an event that may qualify the above employee for continuation of benefits coverage.

Date of Event (e.g., last day of work): _____ **Date of Loss of Coverage (if different):** _____

Please note: Regular coverage will end on the last day of the month in which the event occurred.

Nature of Qualifying Event (circle one):

1. Voluntary Termination of Employment (e.g., resignation)
2. Involuntary Termination of Employment (e.g., laid off) – but not for gross misconduct
3. Death of Covered Employee
4. Retirement
5. Reduction in Covered Employee's Work Hours
6. Covered Employee Now Entitled to Medicare Benefits (only dependents are eligible for COBRA coverage)
7. Divorce or Legal Separation (indicate name of spouse): _____
8. Over-Age Dependent (indicate names): _____

Nature of Gross Misconduct, a Non-Qualifying Event (circle one, if applicable):

9. Illegal Conduct: theft, embezzlement illegal use of drugs, drinking, or gambling
10. Conduct as disruptive, harmful to employer's business or workplace

Note: COBRA is not offered if the event is due to gross misconduct. In the event that employee is terminated due to gross misconduct, HMAA will notify the employee that COBRA coverage is unavailable.

Please cancel this employee from our billing: Yes No

Employer Signature: _____ **Employee Signature (optional):** _____

HMAA must receive this notice within **30 days** of the qualifying event (or within **60 days** of events #7 or #8 above).

Mail to: **HMAA, 737 Bishop Street, Suite 1200, Honolulu, HI 96813** or fax to **(808) 535-8353**.
Do not send payment.

HMAA will send a COBRA Notice and Election Form to the individual upon receipt of this form.