CERTIFICATE OF ELIGIBILITY FOR CONTINUATION OF HEALTH COVERAGE FOR LAID OFF STATE EMPLOYEES WHO ARE COVERED BY A BARGAINING UNIT

Any laid off full-time bargaining unit state employee who was receiving state-paid health benefits prior to the layoff may be eligible to continue to receive such state-paid benefits, as if continuing in active employment, for a period not to exceed **one month** after the date of termination of state employment. This language is in effect for the duration of the 2015 - 2017 bargaining contract period.

Personal Information:

Employee Name:		Home Telephone Number:	
Mailing Address:		Cell Phone Number:	
Apt/Unit #:		Email Address (optional):	
City, State Zip:		Effective Date of Lay Off:	

To qualify for the one-month of state-paid COBRA coverage, you must be able to check "No" for all of the following statements:

1. I am eligible to retire and receive post-retirement health benefits under the provisions of RSA 21-I:26-36 or RSA 100-A:52-55.	☐ Yes	☐ No
2. I am eligible for employer-paid medical or health care coverage through another employer	☐ Yes	☐ No
3. I am eligible for medical or health care coverage through my spouse's employer. Note: If you will become eligible for medical or health care coverage through your spouse's employer at a future date, please indicate the effective date that coverage will begin: ____/____/____	☐ Yes	☐ No
4. I am eligible for medical or health coverage under the State's plan because my spouse is a benefits eligible State employee.	☐ Yes	☐ No

Reason for Qualifying Event: Layoff	**Qualifying Event Date:** (same as "Effective Date of Lay Off")	**COBRA Coverage Start Date:** (first of month following layoff date)

Benefit Elections:

Who Needs to be Covered Under the COBRA plan (they must already be covered on your benefit plan):

Name (first and last)	Social Security Number	DOB	Relationship to Employee (self/spouse/child)	Gender (Male or Female)

Current Division (select one): ☐ **Active** ☐ **Trooper** **Bargaining Unit:** _____

Current Medical (select plan type and coverage): ☐ **HMO** ☐ **POS** ☐ **1-person** ☐ **2-person** ☐ **Family**

Current Dental (select coverage): ☐ **1-person** ☐ **2-person** ☐ **Family**

I elect to exercise my right to continued state-paid health benefits as a laid off state employee. I understand that the one-month of state-paid coverage shall be included in the calculation of my entitlements under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and any amendments thereto. I understand that if I complete this form and return it to the Division of Personnel that I do not need to complete and return the official Anthem COBRA enrollment form when it arrives at my home. *(Please do not discard the official COBRA paperwork when it arrives at your home. You should keep it with your records as it contains important information that you may need to refer to at a later date).* I understand that if I want to continue COBRA beyond the one month of state-paid coverage, that I will be responsible for making the necessary payments to Anthem COBRA by the deadline specified in the official Anthem COBRA notification. I also understand that if I become eligible for other insurance during the first month of state-paid coverage that I am obligated to notify the Division of Personnel. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

_____ _____

Signature of Employee ***Date Signed***

_____

Printed Name

Please mail this completed form to:
or
Fax to 271-1427

Tina Hussey, Division of Personnel
State House Annex
28 School Street
Concord, NH 03301

FOR EMPLOYER OR PLAN USE ONLY

Agency Information:

Name:

Code:

This employee is:

☐ Eligible for Benefits

☐ Ineligible for Benefits (send letter to applicant specifying reason for ineligibility)