

**SAMPLE Model N.J. Continuation Coverage Election Notice**

(send to employee within 14 days of the termination date the carrier specific enrollment form via 1<sup>st</sup> class mail or with a Certificate of Mailing available at any post office)

Date: (Enter the date of the notice)

Dear: (Identify the qualified beneficiary by name)

This notice contains important information about your right to continue your health care coverage (dental may not be continued) with (enter the group health plan carrier name). Please read this notice very carefully.

To elect N.J. Continuation coverage, complete the attached Election Form and submit to us no later than 30 days of your receipt of this notice or your coverage will end (enter the last date of coverage).

Each covered person in your family is eligible to continue.

If your coverage is ending due to termination of employment you and your covered family may continue for 18 months.

Coverage may be extended to 29 months if you are declared Medicare disabled retroactively to a date within 60 days of first becoming eligible for continuation. During this extension we are permitted to charge 150% of the full premium.

If your spouse is eligible to continue due to legal separation or divorce, your spouse and children may continue for 36 months.

A child(ren) who is losing coverage because s/he is no longer eligible as a dependent may continue up to 36 months.

The monthly cost for your continued coverage is (enter the full premium plus the permitted 2% surcharge) which is the full premium charged by (carrier name) plus the permitted 2% administrative charge. This full amount must be submitted with this election form within 30 days . Your monthly premium is due every 30 days thereafter in order to continue your health coverage. If your dependents do not wish to continue, please call this office for the appropriate premium due for yourself or for a dependent only.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title