**TERMINATION & CHANGES TO POLICIES -** Please remember that when you terminate an employee or they are not actively working for you, several things need to take place:

* ***Immediately*** send an enrollment/change form (specific carrier-Horizon/Aetna/Oxford/etc) to Lynne@InsAdvocates.com or fax 863-588-1663 to remove the employee immediately from the policy. You do not want to wait for the employee to give you an answer if they are going to take COBRA/NJ Continuation or not because that means you will probably be stuck with the billing/premium for the 2 months or until you actually remember to remove them from the policy. If they use the policy while they are thinking about State Continuation or COBRA and you didn’t terminate them on or before their termination date, you will be responsible for that premium. Questions, call us or text us at 863-588-1582
* ***Immediately*** (by 14 days) send out the COBRA/state Continuation Letter along with an enrollment form (carrier specific). This letter MUST go out in regular 1st class mail and obtain a Certificate of Mailing Receipt (white form from PO) from the Post Master. Do not send your letter via Fedex, Return Receipt, etc, as this does not hold up in the court system for proof believe it or not. Please read the COBRA Tips letter that we sent to you about that.
* You can use the sample COBRA/NJ Continuation Letter we sent you. However, we are not an Employer Attorney and it is always suggested to have your Employment Attorney review the document.
* If you have more than 20 employees on Payroll (F/T, P/T, Temps, Union, etc) then you usually would send out the COBRA letter. If you have less than 20, then you would use the State Continuation Sample letter. If you end up using the COBRA letter, you are fine, but if you are under 20 ees on payroll, they only have 30 days to notify you to send in the enrollment change form to get this to the carrier to enroll them back on plan under Continuation.
* As long as you have sent us the termination enrollment/change form to remove them from the policy, you just wait for them to respond to your COBRA letter. They have 60 days-COBRA (again, 30 days-Continuation) to respond and for you to enroll them back onto the policy from their original termination date. If they don’t respond to you, you are good. If they do and want COBRA, make sure you get the signed enrollment form and signed COBRA letter over to us ASAP. This is why you should always include the enrollment form within their COBRA/Continuation with their Letter.
* Since you probably don’t have a COBRA Administrator (vendor who handles all of this, you become the COBRA Administrator). The terminated employee is responsible for paying you the back premium and moving forward based on what you indicate on your COBRA letter. You can charge up to an additional 2% on top of the premium (carrier’s premium charged to you on your bill) for administrative fees. You must keep track of their payments to you for the 18 months (36 if is due to Medicare) and you send in the entire check for your group’s premium. I would document the date payment is due, date received payment, with what check#, the amount paid, etc. You do not need to bill them or notify them as your original COBRA Letter states it all.
* If the premium is paid timely and the amount is not significantly less than the full COBRA premium, the plan must either: (1) accept the payment as payment in full; or (2) notify the individual that an additional amount is owed and provide an additional reasonable period to pay the amount owed even if allowed after the grace period. If a check bounces the amount is not significantly less but in fact zero and as such additional time need not be allowed. COBRA election forms and notices should clearly indicate that coverage will be terminated due to nonpayment.
* Remember that when you change your plan due to Open/Annual Enrollment, all options must be given/spelled out to that individual as well via letter.
* Provide a COCC (Certificate of Credible Coverage) for the employee which they will need in order to obtain coverage elsewhere within 60 days (see attached or request one from us).
* ***Remember***, after the employee hasn’t made a payment and you have given them 30 days to do so, you should then send in a termination enrollment change form to remove them from the plan so you are not responsible for payment of this premium. If they should request to be removed from the COBRA coverage (because they got a new job or now they are Medicare eligible, etc, you will also need to send in a completed enrollment change form with their signature requesting to be removed from the plan.

If you should have any questions, please don’t hesitate to contact us as we will try to advise you as much as possible. Again, we are not employment attorney and this is a Department of Labor Law, not an insurance Law. We will try to guide you through the process in laymen’s terms

***Please refer to these other helpful options:***

FAQ’s regarding COBRA: <https://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html>

Sample Letters & info on COBRA: <https://www.dol.gov/ebsa/COBRA.html>

Employer COBRA Handbook: <https://www.dol.gov/ebsa/pdf/cobraemployer.pdf>

Department of Labor NJ: <http://lwd.dol.state.nj.us/>

Department of Labor NY: <https://www.labor.ny.gov/home/> see [NYS Continuation Law](https://www.dfs.ny.gov/consumers/health_insurance/cobra_coverage_extension_36_Months) [NY COBRA Law](https://www.xperthr.com/employment-law-manual/health-care-continuation-cobra-new-york/679/?cmpid=PLC%7cUSAG%7cHUSUN-2016-1110-shrm_content_syndication_superlink%7cArticle16579&sfid=701w00000018zEE&partner=SHRM)

Department of Labor Federal Site: <https://www.dol.gov/>

Church/Congregations: Not eligible for COBRA [**PDF**](https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-for-employers.pdf)

**Below is a Sample COCC (Certificate of Creditable Coverage) which the employee will need in order to obtain other coverage within 60 days of termination (especially through the Marketplace. Please be sure to fill this out for them.**

**NEEDS TO BE ON COMPANY LETTERHEAD**

**CERTIFICATE OF CREDITABLE COVERAGE**

|  |  |
| --- | --- |
| **DATE OF THIS CERTIFICATE** |  |
| ***PLAN ADMINISTRATOR INFORMATION*** |
| **NAME OF PREVIOUS EMPLOYER** |  |
| **ADDRESS, CITY, STATE ZIP** |  |
| **HR CONTACT NAME** |  |
| **HR CONTACT PHONE** |  |
| **NAME OF EMPLOYEE** |  |
| **CERTIFICATE APPLIES TO THE FOLLOWING INDIVIDUALS** |
| **EMPLOYEE** |  |
| **SPOUSE** |  |
| **CHILD** |  |
| **CHILD** |  |
| **INSURANCE CARRIER** |  |
| **GROUP ID #** |  |
| **MEMBER ID #** |  |
| **DATE COVERAGE BEGAN** |  |
| **DATE COVERAGE ENDED** |  |
| **The reason for this loss of coverage is due to (indicate one):** *Termination, Retirement, Non-payment of Cobra, Death of Employee, Disability, other-indicate* |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Humana Resources/Benefits Manager**