

Continuation of Group Health Insurance Coverage Colorado Law

(Groups of 2-19 Employees)

NOTE WELL: Under Colorado Law HB 1353, effective 1/1/03, the employer must notify the insurance company of a termination **NOT LATER THAN the last day of the month terminated!** Premium payment is required for the month in which the insurance company receives notification.

Under Colorado law*, departing employees may continue medical, and dental,[†] coverage under an employer-sponsored group health plan **IF** they were covered under the employer's **current** group plan, **or any group plan it replaced**, for the **6-month period prior to** their termination of coverage. **Every eligible departing employee must be offered – IN WRITING – the option to continue coverage. It is STRONGLY RECOMMENDED that the continuation forms be given to the departing employee in person prior to his/her departure. If this is not possible, it is STRONGLY RECOMMENDED that the forms be mailed to the employee by Certified-Mail-Return-Receipt as proof that the employee was offered continuation. Copies of the notification should be attached to the receipt and filed. FAILURE TO FOLLOW THESE PROCEDURES COULD RESULT IN FUTURE EXPENSIVE LEGAL LIABILITY FOR THE EMPLOYER!** If a departing employee **is not** eligible, the employee should be so advised, preferably in writing.

When an employee is terminated, follow the procedures below. Use the **Group Health Insurance Continuation Form AND** any additional form(s) required by your insurance company. **(Most insurance companies require their own special form.)**

If an employee elects to continue coverage:

- 1) **FAX and mail original forms to your broker at Insurance Planning Services LLC. Broker will forward to the insurance company. IPS LLC fax 303.688.2455**
- 2) Place copies in company file.
- 3) Give copies to departing employee.
- 4) Mail copies to insurance company with the next bill. **Include the departing employee's premium in the group premium. Follow any special procedures required by your insurance company.**

***Remember: The employer is required to pay a departing employee's premium for the entire month of their departure, regardless of the day of departure during that month.

If an employee declines the option to continue coverage:

- 1) **FAX and mail original forms to your broker at Insurance Planning Services LLC. Broker will forward to the insurance company.**
- 2) Place copies in company file.
- 3) Give copies to departing employee.
- 4) Mail copies to insurance company with the next bill.
For most insurance companies: **On the next bill: Line through employee's name, enter termination date, and, if allowed by your insurance company, deduct the departing employee's premium. (NOTE: Most companies prefer that you pay as billed, and wait for the credit on your next bill.) Follow any special procedures required by your insurance company.**
- 5) **NOTE WELL: If an employee terminates on the last day of the month: FAX a termination form directly to the insurance company on THAT day, if possible. If not possible, then FAX on the first business day following. If necessary, the termination form can be signed by the employer, instead of the employee. If so done, cross out "employee", enter "employer", and print the name and title of the employer representative beneath the signature.**

***Remember: The employer is required to pay a departing employee's premium for the entire month of their departure, regardless of the day of departure during that month.

Please read the continuation form(s) carefully! There are other factors concerning continuation that may be pertinent to a particular case. Please direct questions regarding continuation to either your broker or your insurance company.

***NOTE: Colorado State Continuation rules differ in several respects from C.O.B.R.A. rules. C.O.B.R.A. is a federal law, and ONLY applies to companies that employ 20, or more, employees, including both full and part time.**

[†] Continuation does not include life coverage. Dental can be continued only if combined with medical under the same carrier health plan. A stand alone dental plan can not be continued..

Group Health Insurance Continuation Form

(Groups of 2-19 Employees)

Business Name		Group Number	
Business Address			
Employee Name			
Social Security Number		Job Term Date	

Your group health insurance will be terminated effective at the end of this day: ____/____/____. **This day** is the **last day of the month** in which your employment will be terminated (or your hours reduced below the minimum required).

To continue coverage, you must **return this form, and your insurance company's continuation form**, to the **business** above **not later than 30 days after your insurance termination date, or you will lose your eligibility for coverage continuation.**

Under Colorado law, you are entitled to continue your group medical, and dental, insurance coverage for up to 18 months after the date of your group coverage termination, **provided that** you have been covered under the current group plan, or the plan it replaced, **for at least six months.** This continuation of coverage **does not** apply to life coverage.

In order to continue coverage under the group plan, you will be required to pay monthly premiums in the amount of \$_____ for **medical** and \$_____ for **dental.** The premium must be received **each month** at the above address **not later than the 25th of every month PRIOR to the premium due date, OR on the following day designated by the business:** _____, or your coverage will be terminated. (for example: Payment must be received not later than May 25th for the June premium, which is due to the insurance company on June 1st.)

Please indicate your continuation preference in one of the signature areas below.
 (Dental coverage is optional, but it can **ONLY** be continued **WITH** medical coverage, when **BOTH** the medical and dental plans are provided as combined coverage from the **same carrier.**)

<i>I elect to continue coverage at this time.</i>	I wish continuation of MEDICAL coverage to begin on ____/____/____.		
	I wish continuation of MEDICAL and DENTAL coverage to begin on ____/____/____.		
	I understand that my first premium payment is due NOT LATER THAN ____/____/____ to the business.		
	Signature		
	Printed		Date

I am undecided regarding my option to continue coverage. I understand that I must reply in writing NOT LATER THAN 30 days from the date coverage terminated.			
Signature			
Printed Name		Date	

I decline the option to continue coverage.			
Signature			
Printed Name		Date	