**COVID-19**

**COBRA**

With the current state of the economy and numerous businesses shut down amid the ongoing Coronavirus pandemic, we have been getting many requests for COBRA Continuation information and forms. This easy to use summary is intended to provide you everything you need to properly handle COBRA Election notices.

As a reminder, in the state of Pennsylvania, there are two types of COBRA Continuation mandates:

**Federal COBRA Continuation**

* Applies to employer groups that had 20 or more employees on 50% or more of the business days in the prior calendar year (2019).
* Allows for qualified beneficiaries to continue Medical/Rx, Dental, Vision, FSA & HRA coverage for up to 18 months (can be longer in specific instances).
* A qualified beneficiary is any individual, who on the day before the qualifying, is covered under a health plan by virtue of being on that day either an employee; a spouse of a covered employee; a dependent child of the covered employee (including a child covered under the plan pursuant to a qualified medical child support order (QMCSO); or any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.
* The premiums are the responsibility of the qualified beneficiary and the employer can charge up to 102% of the premium.

Please see the next page for **THE FEDERAL COBRA ELECTION FORM**. (Note: Requires some customization)

**Pennsylvania Mini-COBRA**

* Applies to employer groups that had between 2-19 employees.
* Allows for qualified beneficiaries to *only* continue Medical/Rx coverage for a period of time not to exceed 9 months.
* A qualified beneficiary is any individual, who is an employee; a spouse of a covered employee; a dependent child of the covered employee (including a child covered under the plan pursuant to a qualified medical child support order (QMCSO) AND who has been continuously insured under the group policy for the entire three- month period immediately preceding a qualifying event.
	+ Note: Continuation coverage is not available to any person who is covered by (or eligible for) Medicare; fails to verify that he or she is ineligible for employer-based group health coverage as an eligible dependent; or is (or could be) covered by any other group health coverage that the individual was not covered by immediately prior to the qualifying event.
	+ To qualify for extended dependent coverage, a dependent must be a Pennsylvania resident or a full- time student, must be unmarried and have no dependents and must not be covered by other health insurance or a government health care program.
* The premiums are the responsibility of the qualified beneficiary and the employer can charge up to 105% of the premium.

THE PA MINI-COBRA ELECTION FORM is also included in this COBRA packet. (Note: Requires some customization)

# Model COBRA Continuation Coverage Election Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage election notice that the Plan may use to provide the election notice. To use this model election notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model election notice to be good faith compliance with the election notice content requirements of COBRA. The use of the model notices isn’t required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

**NOTE:** Plans do *not* need to include this instruction page with the model election notice.

# Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 1/31/2023)

# Model COBRA Continuation Coverage Election Notice (For use by single-employer group health plans)

**IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives**

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

**This notice has important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at** [**www.HealthCare.gov**](http://www.healthcare.gov/) or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

# Why am I getting this notice?

You’re getting this notice because your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

* End of employment  Reduction in hours of employment
* Death of employee  Divorce or legal separation
* Entitlement to Medicare  Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there’s a “qualifying event” that would result in a loss of coverage under an employer’s plan.

# What’s COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren’t getting continuation coverage. Each “qualified beneficiary” (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

# Who are the qualified beneficiaries?

Each person (“qualified beneficiary”) in the category(ies) checked below can elect COBRA continuation coverage:

1

* Employee or former employee
* Spouse or former spouse
* Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
* Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

# Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

# If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on [*enter date*] and can last until [*enter date*]*.*

[*Add, if appropriate:* You may elect any of the following options for COBRA continuation coverage: [*list available coverage options*].

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

# Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don’t provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit [http://www.dol.gov/ebsa/publications/cobraemployee.html](https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf).

2

# How much does COBRA continuation coverage cost?

COBRA continuation coverage will cost: [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.*]

Other coverage options may cost less. If you choose to elect continuation coverage, you don’t have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

**You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** You can learn more about the Marketplace below.

# What is the Health Insurance Marketplace?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you’ll also learn if you qualify for free or low-cost coverage from [Medicaid](https://www.healthcare.gov/do-i-qualify-for-medicaid) or the [Children’s Health Insurance Program (CHIP).](https://www.healthcare.gov/are-my-children-eligible-for-chip) You can access the Marketplace for your state at [www.HealthCare.gov.](http://www.healthcare.gov/)

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

# When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov.](http://www.healthcare.gov/)

# If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

3

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

# Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

# What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

* Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
* Provider Networks: If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
* Drug Formularies: If you’re currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
* Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
* Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

4

* Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

# For more information

This notice doesn’t fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at [http://www.dol.gov/ebsa](https://www.dol.gov/agencies/ebsa) or call their toll-free number at 1- 866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit [www.HealthCare.gov.](http://www.healthcare.gov/)

# Keep Your Plan Informed of Address Changes

To protect your and your family’s rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

5

# COBRA Continuation Coverage Election Form

**Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.**

**Send completed Election Form to: [*Enter Name and Address*]**

**This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].**

**If you don’t submit a completed Election Form by the due date shown above, you’ll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date.**

**However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.**

**Read the important information about your rights included in the pages after the Election Form.**

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) listed below: Name Date of Birth Relationship to Employee SSN (or other identifier)

1. [*Add if appropriate:* Coverage option elected: ]
2. [*Add if appropriate:* Coverage option elected: ]
3. [*Add if appropriate:* Coverage option elected: ]

Signature Date

Print Name Relationship to individual(s) listed above

Print Address Telephone number

6

# Important Information About Payment

*First payment for continuation coverage*

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don’t make your first payment in full no later than 45 days after the date of your election, you’ll lose all continuation coverage rights under the Plan. You’re responsible for making sure that the amount of your first payment is correct. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

*Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you’ll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due [*enter due day for each monthly payment*] for that coverage period. [*If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

*Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you’ll be given a grace period of 30 days after the first day of the coverage period [*or enter longer period permitted by Plan*] to make each periodic payment. You’ll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you don’t make a periodic payment before the end of the grace period for that coverage period, you’ll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to: [*enter appropriate payment address*]

7



# Continuation Coverage Election Notice for Pennsylvania Mini-COBRA Coverage

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

**This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan).** Please read the information contained in this notice very carefully.

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Continuation Coverage Election Form and submit it to us.

If you do not elect continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box(es)*]:

* End of employment
	+ Involuntary  Voluntary
* Divorce or legal separation
* Death of employee
* Entitlement to Medicare
* Reduction in hours of employment
* Loss of dependent child status

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to nine (9) months *[Check appropriate box or boxes; names may be added]*:

* Employee or former employee
* Spouse or former spouse
* Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
* Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, continuation coverage will begin on [*enter date*] and can last until [*enter date*]*.*

Continuation coverage will cost: [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods – not more than 105% of the group rate of the insurance being continued on the due date of each payment*]. You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact [*enter name of party responsible for continuation coverage administration, with telephone number and address*].

# Continuation Coverage Election Form

**Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Pennsylvania law, you have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage.**

**Send completed Election Form to: [*Enter Name and Address*]**

**This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than [*enter date*].**

**If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.**

**Read the important information about your rights included in the pages after the Election Form.**

I (We) elect continuation coverage in the [*enter name of plan*] (the Plan) as indicated below: Name Date of Birth Relationship to Employee SSN (or other identifier)

a.

1.
2.

Signature Date

Print Name Relationship to individual(s) listed above

Print Address Telephone number

# Important Information about Your Continuation Coverage Rights

**Are there other coverage options besides Mini-COBRA Continuation Coverage?**

Yes. Instead of enrolling in Mini-COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with Mini-COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under Mini-COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between Mini-COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

# What is continuation coverage?

Pennsylvania law requires this group health insurance coverage give employees and their families the opportunity to continue their coverage for up to nine (9) months when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, covered employees and eligible dependents may include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse and the dependent children of the covered employee.

Continuation coverage is the same coverage, with no break in coverage, that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

# Who is eligible, and how long will continuation coverage last?

Employees and eligible dependents who have been continuously insured under the group policy or for similar benefits under any group policy which it replaced, for the three consecutive months ending with the employee’s termination by a qualifying event. Continuation coverage is not available if:

* 1. the employee or eligible dependent is eligible for coverage under Medicare;
	2. the employee or eligible dependent fails to verify that he is ineligible for employer-based group health insurance as an eligible dependent;

or

* 1. the employee or eligible dependent is or could be covered by any other insured or uninsured arrangements that provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to the termination of the employee’s group coverage (excluding Medicaid, CHIP – the Children’s Health Insurance Program, and adultBasic).

Coverage may be continued for up to nine (9) months. However, if any of these three events happens after continuation coverage has begun, eligibility for coverage ends, and the employee or eligible dependent is required to provide written notice to the administrator within fourteen (14) days that coverage should not occur.

In addition, continuation coverage will end:

1. if the employee or eligible dependent fails to make timely payment of a required premium contribution;

or

1. if the group coverage is terminated.

# How can you elect continuation coverage?

To elect continuation coverage, each covered employee or eligible dependent must complete the Continuation Coverage Election Form and furnish it according to the directions on the Form. Unless an eligible dependent’s election otherwise specifies, election of continuation coverage by an eligible dependent will be deemed an election of continuation coverage on behalf of any other eligible dependent who would lose coverage by reason of the qualifying event.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal and state law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage; election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, if you have a right to a conversion policy under section 621.2 of the Insurance Company Law of 1921 (40 P.S.

§756.2), you will lose the right to a conversion policy if you do not elect continuation coverage for the maximum time available to you.

# How much does continuation coverage cost?

Continuation coverage will cost [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods – not more than 105% of the group rate of the insurance being continued on the due date of each payment*]. You do not have to send any payment with the Continuation Coverage Election Form.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).]

# When and how must payment for continuation coverage be made?

[*Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.*]

You may contact [*enter appropriate contact information for the party responsible for continuation coverage administration under the Plan*] to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Your payment(s) for continuation coverage should be sent to:

[*enter appropriate payment address*]

# For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from [*enter appropriate contact information for the party responsible for continuation coverage administration under the Plan*].

If you have any questions concerning the information in this notice, your rights to coverage you should contact [*enter name of party responsible for continuation coverage administration, with telephone number and address*].

For more information about your rights under state law, contact: Pennsylvania Insurance Department

Toll-free, Automated Consumer Hotline: 1-877-881-6388 Harrisburg Regional Office: (717) 787-2317

Philadelphia Regional Office: (215) 560-2630

Pittsburgh Regional Office: (412) 565-5020 ra-in-consumer@state.pa.us

# Keep Your Administrator Informed of Address Changes

In order to protect your and your family’s rights, you should keep [*enter name and contact information for the appropriate party responsible for continuation coverage administration*] informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to [*enter the name of the party responsible for continuation coverage administration*]