

**THE BOARD OF COMMISSIONERS  
TONI PRECKWINKLE, PRESIDENT**

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**DEPARTMENT OF RISK MANAGEMENT**

**Lisa M. Walik, Director**

118 North Clark Street, Room 1072  
Chicago, Illinois 60602-1304

	<u>Telephone</u>	<u>Facsimile</u>
Director:	312-603-6422	866-798-9254
Employee Benefits:	312-603-6385	866-729-3040
Workers' Compensation:	312-603-6590	866-839-5397
General Liability:	312-603-6852	866-841-0447
Safety:	312-603-6759	866-746-9102

**COBRA ELECTION NOTICE**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_  
  
Payroll Number: \_\_\_\_\_  
  
Dept: \_\_\_\_\_

THE FOLLOWING INFORMATION MUST BE SHARED WITH EACH OF YOUR COVERED DEPENDENTS WHOSE COVERAGE IS BEING TERMINATED:

Your coverage under the County of Cook Employee Health Plans will terminate effective \_\_\_\_\_. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that qualified beneficiaries (employee and/or covered dependents) have the option of continuing group health care, dental, vision, and FSA benefits if coverage ended because of the following reasons:

- |  |                               |
|--|-------------------------------|
| 1. Voluntary or involuntary termination of Cook County Employee for reasons other than gross misconduct  | Eligible 18 months            |
| 2. Reduction of employee's working hours   | Eligible 18 months            |
| 3. Death of covered employee   | Dependents Eligible 36 months |
| 4. Divorce or legal separation of covered employee. <b>(In order to be eligible for COBRA the employee or spouse must notify the Insurance Office within 60 days of this event.)</b> | Dependents Eligible 36 months |
| 5. Loss of "dependent child" status under plan rules.  | Dependents Eligible 36 months |

\*If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of termination-or within the first 60 days of COBRA continuation coverage- and he/she notifies the plan administrator within 60 days of the disability determination, the 18 month period is extended to 29 months.

If you or any of your covered dependents decide to continue your current benefits under COBRA, it will become effective immediately upon termination of your current coverage.

**TO ENROLL, FOLLOW THE STEPS BELOW:**

1. Inform the Employee Benefits Office within 60 days from the date of termination of coverage, that you wish to continue your current health insurance benefits.
2. Complete an "Employee Enrollment/Change" form and return it to the Employee Benefits Office. *(Also complete a COBRA Vision/Dental Enrollment Form if you wish to maintain Vision or Dental coverage)*
3. Send your first month's premium payment to the Employee Benefits Office. This premium must be received no later than 45 days from the date you elect COBRA *(the date you indicated on your completed enrollment form)*. It is recommended that the first payment accompany your enrollment form(s).



**Premiums are due by the first of each month.  
Failure to make a required premium will result in cancellation.**

Payments in the form of a Cashiers Check, Money Order, or Certified Check only should be made payable to:

**COOK COUNTY COBRA**

Mail premiums to:

**COBRA  
COOK COUNTY – EMPLOYEE BENEFITS OFFICE  
118 N CLARK STREET, ROOM 1072  
CHICAGO, ILLINOIS 60602**

CONTINUATION OF FLEXIBLE SPENDING – Call Benefits Office

CONTINUATION OF VISION AND/OR DENTAL BENEFITS – See enrollment Instructions #2

COBRA benefits will be terminated under the following conditions:

1. The last day of eligibility has been reached. *(Upon expiration of Coverage under COBRA you will be allowed to enroll in an individual Conversion health plan directly with your health plan)*
2. Non-payment of premium. In compliance with Federal Legislation, payments post marked more than 30 days after the premium due date will not be accepted. They will be returned and your COBRA cancelled.
3. Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation to any pre-existing condition of the beneficiary.
4. A beneficiary is entitled to Medicare.

PLEASE CHECK OFF ONE OF THE OPTIONS BELOW, SIGN THIS FORM AND RETURN IT TO YOUR TIMEKEEPER OR THE INSURANCE OFFICE.

\_\_\_\_\_ I would like to enroll for COBRA. (Your Timekeeper has the Enrollment Forms)

\_\_\_\_\_ I am waiving the option to enroll for COBRA. I understand that if I decide to enroll, that I may revoke this waiver during the 60 day election period.

Print Name \_\_\_\_\_

Date of Qualifying Event \_\_\_\_\_

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_