COBRA Continuation of Coverage Election Form

COBRA benefits will be effective the 1st day of _____ (month) 2024

Note: Rates include a 2% administrative fee. Premiums are due by the 5th of the month for each month of coverage.

COBRA gives you the right to elect coverage independently. You, your spouse or dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage.

Employee Name:	**Event Date:** (loss of coverage or qualifying event)
Email address:	Eligible Dependent(s) / Relationship:
Mailing Address:	Phone Number:

Health Coverage – *complete the attached CalPERS HBD-85 COBRA enrollment form*

Availability depends on Zip Code. Be sure to use the CalPERS online Health Plan Search by Zip Code tool to see if a plan is available in your area. **Selecting a plan that is not available will result in delayed processing of your enrollment.**

Medical Plan		EE only		EE + 1		EE + Family
Anthem Blue Cross Select HMO	☐	$ 1,161.64	☐	$ 2,323.27	☐	$ 3,020.26
Anthem Blue Cross Traditional HMO	☐	$ 1,366.49	☐	$ 2,732.99	☐	$ 3,552.88
Anthem EPO Del Norte	☐	$ 1,340.56	☐	$ 2,681.11	☐	$ 3,485.44
Blue Shield Access+ HMO and EPO	☐	$ 1,098.38	☐	$ 2,196.75	☐	$ 2,855.78
Blue Shield Trio HMO	☐	$ 965.78	☐	$ 1,931.55	☐	$ 2,511.02
Kaiser Permanente	☐	$ 1,041.84	☐	$ 2,083.68	☐	$ 2,708.78
PERS Gold	☐	$ 933.12	☐	$ 1,866.23	☐	$ 2,426.10
PERS Platinum	☐	$ 1,340.56	☐	$ 2,681.11	☐	$ 3,485.44
UnitedHealthcare SignatureValue Alliance	☐	$ 1,112.95	☐	$ 2,225.91	☐	$ 2,893.68
UnitedHealthcare SignatureValue Harmony	☐	$ 956.14	☐	$ 1,912.28	☐	$ 2,485.95
Western Health Advantage HMO	☐	$ 823.37	☐	$ 1,646.75	☐	$ 2,140.78
PORAC Region 1 (Public Safety only)	☐	$ 949.62	☐	$ 2,159.34	☐	$ 2,704.02

Other Coverage – *HR will provide the appropriate enrollment form(s)*

	Individual		Individual + Dependents	
United Concordia Dental	☐	$152.92	☐	$152.92
MES Vision	☐	$ 7.54	☐	$12.92
Magellan EAP (Employee Assistance Program	☐	$ 2.38	☐	$ 2.38

I confirm my enrollment options(s) specified above. I read and understood all materials relating to the option(s) that I selected. My choice is voluntary. I understand City of San Rafael may change the options(s) at any time in accordance with plan terms. In addition, I understand that my participation will be governed by the applicable plan document(s). I understand that I am only allowed to make changes to my elections according to the plan provisions and agree to be bound by the plan provisions of each option in which I participate.

_____ _____

Employee signature Date