

II. Termination of Employee Coverage - See the Sample Forms – Exhibits 4 - 6.

A. Termination of employment

- 1) When an employee has a reduction in hours (that makes the employee ineligible), quits, or is terminated from employment, (s)he is no longer eligible for health insurance benefits. Fill out the special **Termination Form** that is in the employer packet.
- 2) When you fill out the Termination Form, be sure that you include the following information:
 - a) Notification Date: Date that you filled out the paperwork
 - b) Qualifying Event date: Last date the employee worked
 - c) Benefit Term Date: Last date of insurance eligibility – Refer to your group information form. (It will be either the date of termination or the last day of that month.)
 - d) SS#
 - e) Tier Level: Single, Family, etc.
 - f) Name, Gender, DOB, Address
 - g) Original Effective Date: This is the date the **employee's** insurance coverage began.
 - h) Covered Dependents: Fill out Name and Date of Birth for all.
 - i) Qualifying Event Causing Loss of Coverage: Select **Termination of Employment or Reduction of Hours.**
 - j) Prepared By: Give name, phone # and date signed for person who completed the form.
- 3) We recommend that you send all terminations to FCC as soon as they occur. If an employee remains on the premium bill for an extended length of time after (s)he has been terminated, FCC will only allow a retro credit back 3 months for the premium bill. Another problem that may occur if we are not notified in a timely fashion is the overpayment of claims.
- 4) Send the original form to FCC for processing.

B. Other Uses of the **Termination Form**:

- 1) To notify us of the death of an employee
- 2) To notify us of the termination of coverage for non-payment of premiums.

C. COBRA Considerations – for Companies with 20 or more Employees

Notify us in writing of the termination as soon as possible. COBRA laws require that the employer notify the plan administrator within 30 days of the death, termination or reduced hours of the employee.

D. North Carolina State Continuation Coverage – for Companies with fewer than 20 Employees.


It is your responsibility to notify terminated employees, who have been covered under the group plan for three consecutive months immediately before the termination date, that they are eligible for state continuation coverage.

(No continuation coverage is available to a person who is eligible for coverage under another group plan within 31 days after the termination.) Notify us in writing as soon as election and payment are made and we will reinstate coverage for the member. The member will appear on your premium bill as a regular employee. Notify us in writing immediately when the coverage terminates.

Health Insurance:

What Happens to my Coverage if my Job Status Changes?

a consumer's guide to state continuation rights
in North Carolina



One of the responsibilities of the North Carolina Department of Insurance is to inform the insurance buying public. The purpose of this brochure is to help employers and employees better understand their responsibilities and rights under North Carolina's employer group health insurance continuation laws.

These state continuation laws allow employees who terminate employment or lose their eligibility under an employer group health insurance plan to continue coverage under the plan if certain steps are taken. For this reason it is very important that you know and understand your rights and responsibilities. Remember to always take time to read the materials your insurance company or agent gives you and ask questions.



Jim Long

Jim Long
Commissioner of Insurance

Prepared by
The North Carolina Department of Insurance

State Continuation

Our state continuation laws allow terminated employees and members to continue coverage under their employer's group health plan when they terminate employment or lose their eligibility under the plan. State Continuation applies to fully insured plans purchased in North Carolina.

Under State Continuation guidelines, employees who terminate employment for any reason, or whose hours are reduced, or loses eligible employee status may continue their basic health insurance coverage for up to 18 months. Upon termination or loss of eligible status, dependants covered by the policy will also be able to continue coverage for 18 months. Unlike COBRA, State Continuation laws do not provide for extensions of coverage beyond 18 months under any circumstances.

For information concerning the Federal COBRA continuation law please refer to the end of this brochure.

Eligibility

Continuation is available for any employee or covered individual that has been continuously insured under a group policy with the same employer for three consecutive months immediately before the date of termination from the group policy.

Continuation is not available to anyone who is or could be covered by any similar employer or governmental plan for hospital, surgical, or medical coverage within 31 days immediately following the date of termination, regardless of whether or not the new coverage is elected.

Benefits

Hospital, surgical or major medical benefits must be offered under State Continuation. Dental, vision care and prescription drug benefits are not subject to State Continuation guidelines if offered separately.

Notification

Each individual certificate of coverage must include a notice of your right to continue your group health insurance policy. Notification may also be included on insurance identification cards.

Although not required, the employer may give notice orally or in writing as a part of the exit process from employment.

How to Elect State Continuation

The employee or member must request continuation in writing. This is usually accomplished by completing a form furnished by the employer. The employee or member may elect continuation, for a period of at least 60 days, after the date of termination or loss of eligibility.

All premiums required to bring the coverage current must be paid to the employer, upon the election to continue coverage. The coverage shall be reinstated retroactive to the date of termination or loss of eligibility. All subsequent continuation premiums must be paid to the employer in advance.

Premiums cannot be more than the full group rate plus a two-percent administration fee. (PLEASE NOTE: There is no requirement for the employer to subsidize or contribute any portion of the continuation premiums.) Also, there is ***NO GRACE PERIOD FOR PREMIUM PAYMENTS***, therefore, premiums must be paid on or before each due date. However, individuals on State Continuation must be allowed to pay premiums on a monthly basis. In other words, a participant cannot be required to pay premiums on a quarterly, semi-annual or annual basis.

Termination

State Continuation will end on the earliest of the following dates:

- 18 months after the beginning date of state continuation;
- The date ending the period for which the continuation participant last makes his/her premium payment.
- The date the continuation participant becomes or is eligible to become covered for similar benefits under any form of group health coverage, whether they elect coverage or not;

- The date which the group policy is terminated or, in the case of a multiple employer health plan, the date the employer terminates participation under the group master policy. If the employer replaces the group policy with another group policy, the continuation participant is entitled to continue under the successor group policy for any unexpired period of continuation.

The Employer's Responsibilities

The employer is responsible for:

- Offering health insurance continuation to all eligible employees and dependents as required by State law;
- Furnishing all necessary continuation forms to eligible participants so that a written election of continuation can be made; and
- Accepting and remitting premium payments to the insurance company in accordance with plan guidelines.

The Employee's Rights and Responsibilities

The employee has the right to receive:

- Notification of his or her continuation rights;
- All necessary forms needed to apply for continuation; and
- The opportunity to continue his or her health insurance coverage in accordance with state law.

The employee is responsible for:

- Requesting continuation from the employer;
- Completing and submitting all required continuation forms to the employer;
- Paying premiums on time and in a manner satisfactory to the employer (IMPORTANT REMINDER: THERE IS NO PREMIUM PAYMENT GRACE PERIOD AFTER THE DUE DATE); and
- Being aware of all plan guidelines and continuation rules.

Federal Law

Federal COBRA Continuation law applies to employer groups covering 20 and more employees. This law generally allows eligible enrollees the right to continue under the employer group health plan for up to 18 months. The continuation period can be extended beyond the 18-month period in some situations. COBRA continuation law applies to both insured and self-funded plans; however, it does not apply to church plans, plans covering less than 20 employees, and plans covering federal employees. Detailed information concerning your rights under the Federal COBRA laws can be obtained from the Pension and Welfare Benefits Administration Division (PWBA) of the U.S. Department of Labor, Atlanta Regional Office at (404) 562-2156. For a

complete list of publications provided by the PWBA call their hotline at 1-800-998-7542. The U.S. Department of Labor's Web site at www.dol.gov/.



Frequently Asked Questions

Will the terms and provisions of my health insurance change while on State Continuation?

You will be covered on the same basis as if your employment status had not changed.

What happens at the end of the continuation period?

You may be able to convert your coverage to an individual policy under the state conversion provisions. You may also be eligible for an individual guaranteed issue health insurance policy (HIPAA* plan), in the event you are not eligible for other group coverage or Medicare.

What happens if the employer cancels the group policy or goes out of business?

The right to continue your group health insurance will cease.

What happens if the employer switches to a new health insurance company and/or plan?

If the employer replaces the group policy with another group policy, the continuation participant is entitled to continue under the successor group policy for any unexpired period.

** Health Insurance Portability and Accountability Act*

How to Reach Us

How to Reach Us

You Can Reach the North Carolina Department of Insurance Consumer Services Division at:

(800)546-5664 Toll free
(919)733-2032 Outside of North Carolina
(919)715-0319 TDD (Telephone Device for Deaf Caller)
(919)733-0085 Fax

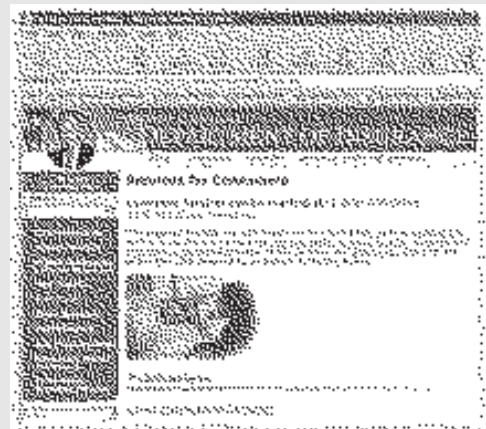
You can find additional information as well as a downloadable copy of our complaint form on the North Carolina Department of Insurance web site at www.ncdoi.com.

The address for the North Carolina Department of Insurance Consumer Services Division is:

Consumer Services Division
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Related Publications Available from the NCDI and its Web Site

HMO Performance Report
Managed Care Plan Consumer Guide
Guide to Appeals and Grievances
A Consumer's Guide to State Continuation
Employer's Guide to HIPAA Rights Regarding Health Insurance
Employees' Guide to HIPAA Rights Regarding Health Insurance
Your HIPAA Rights and Guide to Individual Health Insurance
Getting Off to a Good Start With Medicare
Medicare Changes and Options
Medicare + Choice Comparison Guide
Medicare Supplement Comparison Guide
Guide to Long-Term Care Insurance



SECTION II
EXHIBITS

SECTION II
Termination of Employment

FirstCarolinaCare, Inc.

Termination/COBRA Notification Form

Employer Name ABC COMPANY
Date of Notice 04-17-04 **Date of Qualifying Event** 04-12-04 **Benefit Term Date** 04-12-04 **Group #** 200000
See Your GROUP INFORMATION FORM
OR 04-30-04

Employee Social Security Number 123-45-6789 **Tier Level (SNGL, FMLY, etc.)** SNGL

Employee Name SALLY SMITH **Gender** F **Date of Birth** 06-01-70

Employee Address PO BOX 1234 **City** ANYTOWN **ST** NC **Zip** 20000

Member's Effective Date on Plan
01-01-02

Qualifying Event Causing Loss of Coverage (Check One):

- Employee Termination of Employment (18 Months)
- Employee's Reduction of Hours (18 Months)
- Death of Employee (36 months)
- Divorce/Legal Separation (36 Months)
- Covered employee becomes entitled to Medicare (36 months)
- Ineligibility of Dependent Child (36 Months)

Dependents Covered **Date of Birth**

(use back of form if needed)

Termination for Non-payment of Premiums (Not eligible for COBRA or State Continuation Benefits)

- Cancel employee coverage for non-payment

Prepared By: Susie HR **Phone:** 910-673-1234 **Date:** 04-17-04

FCC Use only: (initial below)
Date Received _____ Date Mailed _____ Travis COBRA _____ CSC Audited _____

SECTION II
Termination for Non-Payment of Premiums

FirstCarolinaCare, Inc.

Termination/COBRA Notification Form

Employer Name ABC COMPANY

Date of Notice 04-17-04 **Date of Qualifying Event** 04-12-04 **Benefit Term Date** 04-12-04 **Group #** 200000

Employee Social Security Number 123-45-6789 **Tier Level (SNGL, FMLY, etc.)** SNGL

Employee Name SALLY SMITH **Gender** F **Date of Birth** 06-01-70

Employee Address PO Box 1234 **City** ANYTOWN **ST** NC **Zip** 20000

Member's Effective Date on Plan
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Qualifying Event Causing Loss of Coverage (Check One):

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Dependents Covered **Date of Birth**

(use back of form if needed)

Termination for Non-payment of Premiums (Not eligible for COBRA or State Continuation Benefits)

Cancel employee coverage for non-payment

Prepared By: Suzie HR **Phone:** 910 673-1234 **Date:** 04-17-04

FCC Use only:		(initial below)	
Date Received _____	Date Mailed _____	Travis COBRA _____	CSC Audited _____

SAMPLE

Company Letterhead

May 1, 2004

Sally Smith
PO Box 123
Anytown, NC 20000

Note: Sally was termed April 30, 2004.

Dear Ms. Smith:

Under North Carolina State Continuation Law, you are eligible to continue health benefits for yourself and your covered dependents, if any, for a period of up to 18 months from the Qualifying Event Date of April 30, 2004, until the date you are eligible for any other group medical coverage, or until the date the group policy is terminated, whichever is earliest. Your coverage can commence on May 1, 2004, the first day after your coverage for the regular group health benefits ends due to termination of employment.

If you decide to continue your group health benefits, please so indicate at the bottom of this form and return it to the return address on this letter along with your premium payment. The total premiums due are shown below. Future premiums are due each month thereafter and should be mailed on or before the due date. Failure to pay premiums by the due date may terminate your participation in the State Continuation Plan. There is NO Grace Period for premium payments.

Sincerely,

Susie Jones
Human Resources Director

(Date of Qualifying Event)

- Date of Termination of Employment
- Date of Member's Death
- Date of Change in Marital Status
- Date Child Ceased to Qualify as a Dependent

(Monthly Premium)

**ALL PREMIUMS MUST BE PAID
BY THE 1st day of EACH MONTH
OR COVERAGE WILL BE
TERMINATED.**

(To be completed by the terminated member)

Coverage is to be continued Yes or No (circle)

**Please retain a copy for your records.

(Signature of person electing continuation)

(Date)

(Social Security Number)

(Mailing Address)

State Continuation Election Form

SAMPLE

Company Letterhead

Today's Date

Name of terminated member
Address
City, State and Zip code

Dear (name of terminated member):

Under North Carolina State Continuation Law, you are eligible to continue health benefits for yourself and your covered dependents, if any, for a period of up to 18 months from the Qualifying Event Date of _____, until the date you are eligible for any other group medical coverage, or until the date the group policy is terminated, whichever is earliest. Your coverage can commence on (last date of coverage + 1 day), the first day after your coverage for the regular group health benefits ends due to (Qualifying Event).

If you decide to continue your group health benefits, please so indicate at the bottom of this form and return it to the return address on this letter along with your premium payment. The total premiums due are shown below. Future premiums are due each month thereafter and should be mailed on or before the due date. Failure to pay premiums by the due date may terminate your participation in the State Continuation Plan. There is NO Grace Period for premium payments.

Sincerely,

(Group Administrator Name)
(Group Administrator Title)

(Date of Qualifying Event)
 Date of Termination of Employment
 Date of Member's Death
 Date of Change in Marital Status
 Date Child Ceased to Qualify as a Dependent

(Monthly Premium)

**ALL PREMIUMS MUST BE PAID
BY THE _____ EACH MONTH
OR COVERAGE WILL BE
TERMINATED.**

(To be completed by the terminated member)

Coverage is to be continued Yes or No (circle)

**Please retain a copy for your records.

(Signature of person electing continuation)

(Date)

(Social Security Number)

(Mailing Address)