# Medical Expense Reimbursement Account
## Employee COBRA Notice & Election Form

Date_____

Company name _____ Employee name_____

Social Security Number _____ Phone _____

Employee address _____
Street Address City State Zip

This is to inform you that although you can no longer be covered under our Unreimbursed Medical Expense reimbursement plan, as of _____, _____, you may continue your benefits under the plan beyond this date for the remainder of the plan year **provided you have a balance in your account (contributions are more than claims paid) at the time of your qualifying event**. If any dependent of yours was covered under the plan, you may also continue their benefits.

**You have 60 days from the date of this notice to notify us of your election.**

If you elect this option, the benefits will be continued until;

- the end of the plan year following _____, _____;
- you become a covered employee under any group health plan that has no limitations or exclusions with respect to any preexisting conditions that you (or your dependent) may have;
- you or your dependent(s) become entitled to Medicare. If you become entitled to Medicare, the continuation coverage period for your dependent(s) begins on the date on which you became entitled to Medicare (or, if applicable, the date of an earlier qualifying event) and extends until the end of the plan year;
- you fail to pay the monthly charge for this coverage on time; or
- our Unreimbursed Medical Expense reimbursement plan is no longer in force;

whichever event is **earliest**.

Before termination of employment, you had elected $_____ of annual healthcare reimbursement benefits, for which you were contributing $_____ per pay period through a payroll deduction. You and each of your dependents separately have the right to continue the full amount of the annual benefit by continuing to pay for this coverage. If you elect to continue coverage a single monthly payment of **$**_____ (includes a **$** 5.25 service fee charge) will be required, and will cover you and your dependents. However, if you do not elect to continue the coverage but your spouse or dependent(s) do, this monthly amount must be paid by each individual in your family who chooses to continue to be covered under the plan. The initial premium payment will be for the coverage period from the date coverage as an employee terminates to the date you sign this election form or the plan year end, whichever is earliest.

**We must receive your first payment within 45 days of the date you sign this election form.**

Monthly payments are due on the first day of the month. If your first payment, or any subsequent monthly payment, is not received on time, you will lose your option to continue coverage. You have a 30 day grace period in which to pay premiums due.

Please complete the bottom portion of this notice. Keep a copy for your records and return the original copy to:

**PIOPAC Fidelity**
**1132 Bishop St. Suite 2101**
**Honolulu, HI 96813**

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- I wish to continue my employee benefits under your Medical Expense Reimbursement plan for myself and my spouse and dependent(s) ☐ Yes ☐ No
- The following family members wish to continue individual coverage under your Medical Expense Reimbursement plan:

*Spouse/Dependent Name* *Monthly Amount*

_____

_____

_____

- My first payment is enclosed ☐ Yes ☐ No
- I will make my first payment within 45 days ☐ Yes ☐ No
- Signature _____ Date _____

**IMPORTANT:** In order that your coverage may continue, we must receive:
1. A completed copy of this notice by_____.
2. Your first payment within 45 days following the date you sign this form.