California Group Health Coverage

Employer Notice of Occurrence of Qualifying Event For The Right to Continuation Coverage under Supplemental CalCOBRA Upon Exhaustion of Federal COBRA

Please Print

Name of Employee			Name of Employer		
Address			Address		
City	State	Zip Code	City	State	Zip Code

Employee Social Security Number	COBRA Effective Date	COBRA Termination Date
Date of Qualifying Event/Termination of Coverage	Today's Date	Group Control Number

California Continuation of Group Health Coverage is available to the above employee and any dependent(s) as a result of exhausting Federal COBRA.

The group health coverage under which the above individual(s) have been covered will cease because of the reason and on the COBRA Termination Date indicated above. An Election Form to Continue Coverage will be sent by Aetna to the qualified beneficiary. If the qualified beneficiary elects continuation and pays the premium, elected benefits will be reactivated without lapse in coverage.

A. Within 31 days after the above event or the termination of coverage, whichever is later, the employer must complete and return this form to:

Aetna Inc.
Plan Sponsor Services - Supplemental CalCOBRA
P.O. 24021
Fresno, CA 93779-4021

Telephone: 1-888-667-8544

B. Within 14 days of receipt, Aetna will send an Election Form and premium information directly to the qualified beneficiary.

C. If the qualified beneficiary wishes continued coverage, s/he must notify Aetna in writing within 60 days of the later of:
- The date Federal COBRA ceases;
- The date the employee is given notice.

D. The first premium payment must be received by Aetna within 45 days of the date the qualified beneficiary provides written notice of election.

Name and Address of all Other Group Members (Covered Spouse and Covered Dependent Children)

Name	Address	City	State	Zip Code
1.				
2.				
3.				