COBRA Form A

CSI INSURANCE PLAN AND TRUST FUND

NOTICE OF ELIGIBILITY
FOR
CONTINUATION OF GROUP HEALTH COVERAGE

Name of Covered Employee____ Date______________________

Name of Employer____

Check the Qualifying Event, and in the space following, **enter the date of the Qualifying Event**

__**Termination of employment**____________ **Death of employee** ___________________
__**Reduction of hours** ____________ **Divorce/legal separation** ___________________
__**Medicare election** ____________
__**Dependent no longer qualifies for coverage because of: (give date)**
____age; give dependent's date of birth __________________
____no longer full-time student _________________________
____marriage ___________________
____no longer resides with employee _____________________
____other____

List qualified dependents (spouse, ex-spouse, dependent child):

Name_____________________________________ Relationship____________________________________
Name_____________________________________ Relationship____________________________________
Name_____________________________________ Relationship____________________________________

Address of spouse/ex-spouse ____
____

Under the terms and conditions of the continuation of coverage provisions contained in the CSI Insurance Plan, you and your qualified dependents are eligible to continue coverage of health and/or dental benefits until the earlier of 18 or 36 months following the date of the qualifying event (refer to Optional Continuance of Health Coverage in your Plan book), or the date one of the following occurs (if earlier):

- an individual on continuance becomes covered under another group health plan which has no pre-existing condition limit (see Note),
- an individual becomes covered for Medicare benefits,
- the required payments are not made within the specified time, or
- the group health plan is terminated for all employees.

Note:
1. If you become covered under another group health plan which contains a pre-existing condition limit, you will be eligible to continue CSI coverage during the period of the limitation.
2. If you are an eligible dependent and are disabled on the date of a qualifying event, you should so notify the Administrator, CSI Group Insurance Plan, with your application.

A monthly premium for the coverage will be due and payable on the first day of each month for which coverage is to be continued. Failure to pay this amount by the first of each month will result in loss of coverage. Monthly payment amount: Single_______ Emp. + Ch_______ Emp. + Sp_______ Family______

You will be billed separately for any premium amount due for the period between the date of the qualifying event and the date you elect continuation of coverage. You will have 45 days from the date you elect to continue coverage in which to make this payment.

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If you wish to continue your group health coverage, complete Items 1 through 15 on the attached Application/Waiver form and return the completed form to CSI Insurance. In order for your health and/or dental coverage to continue, you MUST SEND IN YOUR APPLICATION FORMS WITHIN 60 DAYS of the later of: (1) the date that notice of your COBRA rights was sent to you: or (2) the date you, as the qualified beneficiary, actually lost your health coverage as a result of the qualifying event.

Send the Forms A & B with the CSI Group Enrollment Form (and the Priority Health Enrollment Form if necessary) to:

CSI INSURANCE PLAN
3350 East Paris Ave. SE
Grand Rapids, MI 49512

Note: You must inform each of your dependents of the option to continue coverage. Even if you choose not to continue coverage any of your qualified dependents could elect to continue coverage.

If you do not wish to continue coverage, you must complete Items 1 through 8 on the Application/Waiver form on Form B. Then sign and date the waiver portion, and return Form B to the above address.

If you have any questions about the information in this notice or about the continuation of coverage provision, please contact the CSI Insurance Plan office.