MASSACHUSETTS CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

_____
[*Enter date of notice*]

Dear: _____
[*Identify the qualified beneficiary(ies), by name or status*]

This notice contains important information about your right to continue your health care coverage under the group health plan (the Plan). Please read the information contained in this notice very carefully.

To elect Massachusetts Continuation of Coverage ("MA COC"), follow the instructions on the attached election form, and return the election form to the employer group within the required time frame.

If you do not elect MA COC, your coverage under the Plan will end on _____.
[*enter date*]

Each qualified beneficiary is entitled to elect MA COC, which will continue group health care coverage under the Plan for up to 18, 29 or 36 months depending on your qualifying event. If elected, MA COC will be effective the day after group coverage is lost due to the qualifying event.

MA COC will cost monthly:

Individual rate: _____
[insert individual rate +2%]

Family rate: _____
[insert family rate +2%]

Payment for continuation coverage is due monthly to the employer group by the _____ of the month.
[insert due date]

You do not have to send any payment with the Election Form. Important additional information about payment for MA COC is included in the following pages.

If you have any questions about this notice or your rights to MA COC, you should contact [***enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address***].

Massachusetts Continuation of Coverage Benefit Election Form

Name _____
Street Address_____
City_____ State____ Zip Code_____
Tufts Health Plan ID Number _____
(please refer to your membership card)
Social Security Number _____
(if different from ID Number)
Name of Employer Group _____

Please check off the following statements after you have carefully read each one. Agreement with each point is mandatory in order to receive your Continuation of Coverage Benefit. After completing this form, please return it to the employer group. This form must be completed and returned within 60 days from the later of: the postmark date of this notice or the date coverage terminated due to the qualifying event. If this form is not returned within the 60 day time period, you lose your right to elect Continuation of Coverage.

- ❑ **I elect to continue coverage with Tufts Health Plan under the Massachusetts Continuation of Coverage Law. I elect this coverage for:**
  - ❑ **Myself**
  - ❑ **Spouse**
  - ❑ **Dependents: _____**
    (please identify)

- ❑ **I understand that the monthly premium rate for Massachusetts Continuation of Coverage may be 102% of the group rate. Otherwise, the terms and conditions of my group coverage will remain in effect during the continuation period.**

- ❑ **I will pay the first premium to the employer group within 45 days of the date of my election. I will pay subsequent premiums to the employer group within 30 days of the due date.**

- ❑ **I understand that the new Continuation of Coverage Plan will be effective on the date after the group coverage ends.**

Date my group coverage ends: (month)_____ (date)_____(year)_____

Signature_____Date_____

Employer Group Signature _____ Date_____
Tufts Health Plan Employer Group Number _____ - 001