

**AUBURN UNIVERSITY**  
**Salary Reduction Agreement**  
(For the Auburn University §125 Flexible Benefit Plan)  
**NEW HIRE**

\_\_\_\_\_  
**Employee Name**

\_\_\_\_\_  
**Banner ID #**

**Participation in the Auburn University Benefit Plan:** Please indicate your enrollment choices for the Benefit plans below. Select the Plan in which you intend to participate and enter the Effective Date for Coverage (beginning date of coverage). If you are opting out of coverage write today's date and initial.

- Health Plan                      Effective Date: \_\_\_\_\_
- Dental Plan                      Effective Date: \_\_\_\_\_
- Vision Plan                      Effective Date: \_\_\_\_\_
- Flex Plan                      Effective Date: \_\_\_\_\_
- Cancer Plan                      Effective Date: \_\_\_\_\_
- Critical Illness Plan      Effective Date: \_\_\_\_\_
- Voluntary Long Term Disability Plan                      Effective Date: \_\_\_\_\_
- Voluntary Long Term Disability Buy Up Plan      Effective Date: \_\_\_\_\_
  
- Opt out of Health                      Effective Date: \_\_\_\_\_
- Opt out of Dental                      Effective Date: \_\_\_\_\_
- Opt out of Vision                      Effective Date: \_\_\_\_\_
- Opt out of Flex                      Effective Date: \_\_\_\_\_
- Opt out of Cancer                      Effective Date: \_\_\_\_\_
- Opt out of Critical Illness      Effective Date: \_\_\_\_\_
- Opt out of Voluntary Long Term Disability                      Effective Date: \_\_\_\_\_
- Opt out of Voluntary Long Term Disability Buy Up      Effective Date: \_\_\_\_\_

**ACKNOWLEDGEMENT:**

*"My signature below acknowledges the following:*

- *I have chosen to enroll in the benefit plan (s) as indicated above as offered under the terms of the Auburn University Flexible Benefit Plan.*
- *I understand that, in addition to this Salary Reduction Agreement, I **must** also complete an online Enrollment Application for the benefit plan in which I choose to enroll in.*
- *For the benefit plan in which I am enrolled, I agree that my future salary will be reduced by the relevant cost of the benefit plan. If there is not enough salary to take the premiums, I will pay the premiums by cash or personal check in order to maintain coverage.*
- *This Salary Reduction Agreement shall be irrevocable and remain in effect until a participation option is changed or terminated.*
- *New enrollments/changes for currently covered employees and dependents can only be made in accordance with the federal regulations and the Health Insurance Portability and Accountability Act (HIPAA).*
- *If I choose to opt out, I acknowledge that I have been informed of my rights to receive such benefits from a plan sponsored by Auburn University and that I am choosing not to elect the coverage made available to me above.*
- *I understand that the General Notice of COBRA Continuation Coverage Rights will be mailed to me at the address on file.*
- *I understand that if I do not return this form to Human Resources, Payroll and Employee Benefits in a timely manner, the start date of my benefit(s) coverage may be delayed."*

\_\_\_\_\_  
**Signature of Employee**

\_\_\_\_\_  
**Date**

# AUBURN UNIVERSITY

## COBRA Continuation Coverage Rights

### GENERAL NOTICE:

This notice generally explains COBRA coverage, when it may become available to you and your covered dependents, and what you need to do to protect the right to receive it.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires an employer to make available temporary continuation of coverage to participants in any group health plan or group dental plan following any event which would normally cause that coverage to end. Because you are a participant in the Plan you must be provided with this notice.

COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health, dental and vision benefits offered under the Plan and not to any other benefits offered by the University. Under certain circumstances COBRA continuation coverage could also apply to the Auburn University Flexible Spending Account Plan if you are a participant in that Plan.

COBRA coverage can become available to you when you would otherwise lose your coverage under the Plan. It can also become available to your dependents if they are covered under the Plan when they would otherwise lose their coverage under the Plan. This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under the Plan and under federal law you should review the Plans' summary plan descriptions or contact Auburn University Payroll & Employee Benefits, or the Plan Administrator for that specific benefit plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

### What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly provided to the University, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You and your covered dependents could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under a qualified medical child support order (QMCSO) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Individuals who are eligible for COBRA continuation coverage are also eligible to enroll in individually purchased health insurance coverage through the National Health Insurance Marketplace. For more information, go to [www.healthcare.gov](http://www.healthcare.gov).

### Who is Entitled to Elect COBRA?

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent/employee dies;
- The parent/employee's hours of employment are reduced;
- The parent/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child."

### COBRA Continuation Coverage for Sponsored Adult and/or Sponsored Child Dependents

A Sponsored Adult and/or Sponsored Child Dependent is not recognized under COBRA. However, in certain circumstances, federal regulations may require that a Sponsored Adult Dependent (and any relevant Sponsored Child Dependents) be offered continuation coverage in the same manner as a spouse and his/her dependents. In these circumstances, any reference to "spouse", "dependent child" or "dependent children" in this Notice would apply to your Sponsored Adult and/or Sponsored Child Dependent accordingly.

### Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order

(QMCSO) received by the University during the covered employee's period of employment with the University is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Payroll & Employee Benefits has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, the reduction of hours of employment or the death of the employee, Payroll & Employee Benefits will be notified by the Human Resources office of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify Payroll & Employee Benefits within 60 days after the qualifying event occurs.

### **Electing COBRA?**

Once Payroll & Employee Benefits receives notice that a qualifying event has occurred, the Plan Administrator for each benefit plan will contact each qualified beneficiary and offer COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA.

### **How Long does Cobra Coverage Last?**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

When the qualifying event is the end of employment or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or the reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

The coverage period described here are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons which will be explained to you by the Plan Administrator when you become eligible for COBRA coverage. These reasons are also described in the summary plan description for the Plan.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

#### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator or to Payroll & Employee Benefits. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), HIPAA, and other laws affecting group health plans, including COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website.

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep Payroll & Employee Benefits, or the Plan Administrator, informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Payroll & Employee Benefits or to the Plan Administrator.