PRIMARY COVERAGE SELECTION FORM

(See reverse side for COBRA/OBRA Explanation)

EMPLOYER _____ GROUP NO _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

Write in the appropriate information for the ***active employee*** who is over age 65 or disabled and is affected by COBRA or OBRA.

Employee's Name _____ ID# _____ Group # _____

Age _____ Birthdate _____ Effective Date of Change _____

Chose and mark one of the following options: *(Note: If no election is made, group coverage is primary.)*

☐ I choose my group health care program as my primary coverage.
☐ I choose Medicare as my primary coverage.

Please read and sign: I have been informed of the choices available to me in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and OBRA. I understand the consequence of my decision, have elected the health care coverage program as marked above as my primary coverage, and submit my signed authorization to proceed.

Employee Signature _____

Write in the appropriate information for the ***spouse/dependent of active employee*** who is over age 65 or disabled and affected by COBRA or OBRA.

Spouse/Dependent's Name_____ ID# _____ Group # _____

Age _____ Birthdate _____ Effective Date of Change _____

Chose and mark one of the following options: *(Note: If no election is made, group coverage is primary.)*

☐ I choose my group health care program as my primary coverage.
☐ I choose Medicare as my primary coverage.

Please read and sign: I have been informed of the choices available to me in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and OBRA. I understand the consequence of my decision, have elected the health care coverage program as marked above as my primary coverage, and submit my signed authorization to proceed.

Spouse/Dependent's Signature _____

Employer Authorization

Please process the above changes and adjust enrollment records and applicable billings accordingly.

Employer Authorization Signature _____

For Processing, return a copy of this form to: Benefits Coordinator, Wood County Commissioners' Office
One Courthouse Square, Bowling Green, Ohio 43402

COBRA/OBRA REQUIREMENTS

Definition of Law

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to any employer of 20 or more employees who contributes to the cost of employee health plan coverage, including self-funded ERISA programs in both the public and private sectors.

The law requires affected employers to make available to an active employee over the age of 65 the same group health plan coverage provided for employees under age 65.

A dependent spouse is also affected if that spouse is over age 65.

The COBRA law also provides that affected active employees and/or their covered spouses over age 65 may choose to retain Medicare as their primary health care coverage.

OBRA law (effective January 1, 1987) requires employers with 100 or more active employees to offer their group health care plan as primary coverage to disabled employees of any age who are entitled to Medicare. This is in accordance with Federal Law – the Omnibus Budget Reconciliation Act of 1986 (OBRA). The law applies to disabled Medicare beneficiaries (except end-stage renal disease beneficiaries) when covered as an employee or as a dependent of an employee.

If the individual selects regular group coverage as their primary coverage, then:

- The group policy is primary and Medicare becomes secondary. All claims are first filed under the group insurance program.
- This individual may still file for Medicare benefits after the group program has paid.

If the individual selects Medicare as their primary coverage, then:

- Group coverage supplementing Medicare is terminated with the employer, and the individual is allowed to directly purchase non-group coverage supplementing Medicare.
- Only non-Medicare-related group benefits may be maintained through the group: i.e., dental, vision, drug, life insurance, etc., if such benefits are part of the group program.