

**Associated Industries Management
Services (AIMS)**

Voluntary Waiver of COBRA Services



This agreement identifies **Associated Industries Management Services**, (hereinafter, "**AIMS**") as Administrator of **Trust**, and _____ (company name), (hereinafter, "**The Company**") an Employer-participant in the Trust which provides large group health plan benefits. In general, **AIMS** provides notification and administration services related to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) on behalf of the employer participants in the Trust. By this agreement, **The Company** knowingly and voluntarily declines these services effective_____.

1. COBRA Obligations: In summary, COBRA and applicable federal regulations require that continuation coverage for group health plan benefits must be offered by employers of twenty (20) or more workers to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to specific qualifying events.

a. Qualifying Events:

1. The death of a covered employee;
2. Separation of the covered employee from employment for reasons other than gross misconduct;
3. Reduction in the hours of employment for a covered employee for reasons other than gross misconduct;
4. The covered employee has become entitlement to Medicare;
5. Divorce or legal separation from a covered employee; &
6. A child's loss of dependent status pursuant to the plan.

b. Notice Obligations: Once a qualifying event occurs, qualified beneficiaries must be provided an election notice, which fully and clearly describes their rights to continuation coverage and how to make an election. This notice must be provided within fourteen (14) days after notice of a qualifying event. The employee, spouse or dependent is then given at least sixty (60) days from the date the notice is provided or the date coverage would end, to elect to continue coverage. Each of the qualified beneficiaries for a qualifying event may independently elect continuation coverage. The covered employee or the spouse must be allowed, however, to elect on behalf of any dependent children or on behalf of all of the qualified beneficiaries.

c. Cost: The employer may charge the full cost of premiums plus two percent for administering the continued coverage.

d. Period of Continuation Coverage: Generally, upon separation, for reasons other than gross misconduct, or a reduction of hours resulting in loss of coverage, employees may continue on the medical plan for eighteen (18) months at their own cost. Spouses or dependents are able to continue coverage for up to thirty-six (36) months following a divorce from or death of the covered employee. Dependents may also continue coverage at their own cost once dependent status is lost. An individual may become eligible for an extension of the maximum time period for up to eleven (11) more months if the qualified beneficiary is disabled or a second qualifying event occurs. Additional specific notification requirements and costs apply to these circumstances.

2. Waiver of COBRA Services: Having been informed the employer is required to provide notification and administration for continuation coverage pursuant to COBRA, **The Company** knowingly and voluntarily declines COBRA services as provided by **AIMS** effective _____. By doing so, **The Company** understands it takes full responsibility for all notification and administration obligations pursuant to federal COBRA regulations, including administration of notices and benefits for those having elected continuation benefits prior to the effective date of this waiver. **The Company** does hereby indemnify and hold harmless **AIMS** from any and all loss, damages or liability incurred in complying with COBRA as described in this waiver. In the event that **AIMS** is made a party to any investigation, or legal proceeding of any kind or nature or subject to any penalties or excise taxes arising out of **The Company** waiver of COBRA services hereunder, directly or indirectly, to **The Company** agrees to indemnify and hold **AIMS** harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting therefrom. Any information relevant to **The Company**, COBRA responsibilities or obligations received by the Trust will be immediately forwarded by US mail. Further, **The Company** takes on all liabilities and penalties associated with any violation of the notice and administrative obligations set forth by COBRA. The Trust and **AIMS**, along with its officers, directors, agents, representatives, employees, and any subsidiaries are released from any obligations, responsibilities, or claims in relation to these liabilities, penalties COBRA notification and/or administration duties, if any.

3. Signatures Signify Agreement: Both **AIMS** and **The Company** agree to the rejection of the Trust's COBRA services effective _____. The signatures below verify this fact.

4. COBRA Administrator Contact Information: All communications, enrollment updates, eligibility changes and premium payment must be directed to **AIMS** only. Change requests or payments made directly to the carriers will delay enrollment and cause disruption in COBRA beneficiaries' coverage.

Please provide the following information on the company's third-party COBRA administrator.

COBRA Administrator Contact Information			
Company Name:	Company Phone: () -	Company Fax: () -	Web Address:
Address:	City	State	Zip
Contact Name:	Contact Phone: () -	Contact Fax: () -	Email Address:

Dated this the _____ day of _____, 2_____.

Company Name

Associated Industries Management Services

 Name Date

 Deb Brady Date

Title: _____

SVP, Benefit Services Operations