BEST Life™
BEST Life and Health Insurance Company

NOTICE: RIGHT TO CONTINUE GROUP HEALTH COVERAGE (FEDERAL LAW – PUBLIC LAW 99-272) AND COBRA ELECTION FORM

Date Mailed:

<table>
<tr><td>Customer Number</td><td colspan="2">Employee Name</td><td>Employee Number</td></tr>
<tr><td rowspan="3">Name & Address of Employer</td><td colspan="3">Name of Person Applying for COBRA</td></tr>
<tr><td>Relationship to Employee</td><td colspan="2">Social Security Number of Person Applying for COBRA</td></tr>
<tr><td>Date of Qualifying Event</td><td colspan="2">Date Coverage will end unless COBRA Continuation Elected</td></tr>
<tr><td colspan="4">Qualifying Event</td></tr>
</table>

ELECTION

In order for your coverage to continue you must:

- Complete, sign and date the bottom portion of this form and return to your employer within the 60-day period described on the COBRA Continuation option page, and
- Remit initial premiums to employer with election form or within 45 days from the date you elect Continuation by returning this form.

Failure to do either of the above within the time frames described will **void** your right to apply for COBRA Continuation. Continuation coverage will not begin until both the Election Form and the initial premiums are received by BEST Life.

Monthly Premium Due to BEST Life:

Coverage for yourself only: $_____

Coverage for former dependent only: $_____

Coverage for yourself and your eligible and previously covered dependents: $_____

Amount due to employer if different from above (see reverse side under contributions): $_____

ELECTION STATEMENT

I request continuation of my BEST Life medical/dental/vision coverage. I certify that the Qualifying Event indicated on this form occurred on the date shown. I certify that I have read this NOTICE and COBRA ELECTION FORM, understand it and agree to immediately notify BEST Life if I become covered under any other group health plan or become covered under Medicare benefits. I also understand that failure to remit premium when due will result in cancellation of this continued coverage and that no reinstatement will be offered.

I elect to continue coverage for (please select one):

☐ Myself only ☐ Myself and my previously covered eligible dependents (as listed below) ☐ My former dependent only

Spouse's Name: _____ Children's Names: _____

_____

_____

Signature: _____ Date: _____

NOTE TO THE EMPLOYER: It is the employer's responsibility to send the signed Election Form to BEST Life along with an employer check for the initial premiums as soon as both this form and the premium have been received from the individual (Election Form due within the allowable 60 days and employee's payment due within the 45 day period). No coverage will begin until BEST Life has received this completed Form and the initial premium (which includes the amounts due for all months from the date coverage ended through the month following the 45 day period), the individual will be reactivated and once again appear on your monthly invoices. Premiums should then be remitted in routine along with your monthly payments. After the initial premium, do not send separate checks for individuals with COBRA Continuation coverage.

EMPLOYER CERTICIFICATION: I certify that the employer named at the top of this form employed at least 20 employees on at least 50% of its working days during the **preceding calendar year**.

_____ _____ _____ _____

Print Name of Authorized Employer Signature Title Date

COBRA CONTINUATION OPTION

If the BEST Life medical/dental/vision plan sponsored by the employer would otherwise terminate as a result of certain Qualifying Events, employees and dependents may elect to continue coverage subject to the provisions below. Life and disability coverage do not quality for COBRA Continuation.

The coverage being continued will be identical to the medical/dental/vision coverage provided at that time to similarly situated individual to whom a Qualifying Event has not occurred. It will be continued for the period beginning when coverage would otherwise end because of a Qualifying Event and ending as indicated below.

PERIOD OF CONTINUATION

An **employee** may elect continued coverage up to *18 months for the following Qualifying Events:

1. termination of employment for reasons other than gross misconduct, or
2. reduction of hours which results in loss of health plan eligibility.

A **dependent** may elect continued coverage up to **36 months** for the following Qualifying Events:

1. death of the covered employee,
2. divorce or legal separation,
3. covered employee becomes entitled to (covered under) Medicare, or
4. termination of child's dependent status.

A **retiree** who would lose coverage because the employer has filed for reorganization under Chapter 11 of the Bankruptcy Code may have coverage extended for a period of time longer than 18 months. If the retiree dies, the covered surviving spouse and dependent children may elect to extend continued coverage up to a maximum of 36 months from the original date COBRA coverage became effective.

WHEN CONTINUED COVERAGE TERMINATES

If elected, the continued coverage would terminate before the *18 or 36 months period if any of the following events occur:

1. the employer's group health plan is terminated,
2. the employer's participation in the BEST Life Plan is canceled,
3. the continued person fails to make timely payment of premium,
4. the continued person becomes entitled to (covered under) Medicare benefits,
5. the continued person becomes a covered employee under any other group health plan, if that plan does not limit or exclude coverage for any pre-existing condition of the continued person, or
6. former spouses who have continued coverage remarry and become covered under another group's health plan, if that plan does not limit or exclude coverage for any pre-existing condition.

NOTE: A Conversion option must be offered when continued coverage ends only if your continued coverage reaches the *18 month or 36 month maximum Continuation Period.

*The maximum coverage period is extended from 18 to 29 months for certain disabled qualified employees. In order for you, your spouse or dependents to obtain the 29 month maximum coverage period, the continuee must notify BEST Life that Social Security determined he or she was, or became, totally disabled under Title II or XVI of the Social Security Act, at the time of employment termination or reduction in hours, or at any time during the first 60 days of COBRA continuation coverage. **The employee must provide the notice within 18 months of the qualifying event and 60 days of the determination date.** Also, the employee must notify BEST Life within 30 days of any final determination by Social Security that he or she is no longer disabled. Continuation coverage will end sooner if the disability ends.

ELECTION PERIOD

The employee or dependent has **60 days** to elect COBRA continuation. The 60-day period begins on the date coverage would otherwise terminate, or on the date shown on this notice, whichever is later.

Unless otherwise specified by the employer, an employee's election to continue coverage will be deemed to include an election on behalf of the spouse and dependent children who would also lose coverage because of the same qualifying event. Similarly, unless otherwise specified, a former spouse's election to continue coverage will be deemed to include an election for dependent children who would also lose coverage because of the same qualifying event.

CONTRIBUTIONS

In order for your coverage to continue, premium must be remitted to BEST Life by the employer. The employer may require that you pay all or part of the premiums.

Your first premium payment to the employer is due **45 days** from the date you elect continuation by returning this form. This initial premium due include amounts due for all months beginning with the month following the date your coverages would otherwise have ended (see date on top of reverse side) **through** the month following the 45-day period. Thereafter, monthly payments will be due on the first of the month for that month's coverage. The employer will give you specific dates by which these monthly payments must be received by the employer.