

To apply for ARRA Premium Reduction, complete this form and return it to us along with your Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: [Enter Name and Address]

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA, as Amended."

[Insert Plan Name]

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

[Insert Plan Mailing Address]

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

Please answer the questions below.

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point between September 1, 2008 and May 31, 2010 AND the loss of employment occurred on or after March 2, 2010 but by May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am eligible for other group health plan coverage (or I was eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I am eligible for Medicare (or I was eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

FOR EMPLOYER OR PLAN USE ONLY

This application is: Approved Denied Approved for some/denied for others (explain in #5 below)
Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and May 31, 2010.	<input type="checkbox"/>
3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010 or after May 31, 2010).	<input type="checkbox"/>
4. Individual did not elect COBRA coverage.	<input type="checkbox"/>
5. Other (please explain)	<input type="checkbox"/>

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Plan Name

Participant Notification

Plan Mailing Address

PERSONAL INFORMATION

Name and mailing address

Telephone number

E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan.
If any dependents are also eligible, include their names below.

Insert date you became eligible _____

I am eligible for Medicare.

Insert date you became eligible _____

IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature → _____ Date → _____

Type or print name → _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

