



GUIDE TO COMPLYING WITH THE NEW COBRA SUBSIDY FOR TERMINATED EMPLOYEES

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INTRODUCTION

Generally, COBRA (Consolidated Omnibus Budget Reconciliation Act) extends group health benefits provided by a worker's group health plan for limited periods of time under certain circumstances. Those circumstances include such events as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan. Unless special circumstances exist, the typical worker can extend his or her health plan coverage up to 18 months.

In determining whether an employer must adhere to COBRA regulations the employer must have a "group health plan with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year. Both full and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time." (Department of Labor website)

Although COBRA governs employers with 20 or more employees, under Maryland law, most employers – even those with fewer than 20 employees who are not covered by federal COBRA laws – are obligated to offer continuation coverage to former employees for up to 18 months. Maryland's continuation coverage regulations are "applicable to all group health policies or contracts issued or delivered in the State to the employer of the insured which provide hospital, surgical, medical, or major medical benefits on an expense-incurred basis..." (*Code of Maryland Regulations 31.11.04.03*) Thus, the size of the employer is not significant in determining whether an employer must offer continuation coverage.

Rather, all employees who are "Insured" must be offered continuation coverage if the employee has an "Applicable Change in Status." (*Code of Maryland Regulations 31.11.04.02*) An "Insured" is an employee who is a resident of the State and covered under a group policy for at least three months. Applicable Change in Status is defined as "the termination of the insured's employment other than for cause." The term includes:

- Involuntary termination of the insured's employment other than for cause; and
- Voluntary termination of the insured's employment by the insured.

On February 17th, 2009, President Obama signed The American Recovery and Reinvestment Act (known commonly as the "Stimulus Plan" or the "Stimulus Act" or the "Act" or "ARRA") into law. Among the many items addressed in the Act, was a provision that extends subsidized group insurance coverage to terminated, unemployed workers under COBRA, requiring employers to offer eligible individuals **a subsidy equal to 65 percent of the their COBRA premium cost for up to nine months**. This subsidy is extended to dental, vision and mini-med plans, but excludes health flexible spending account coverage offered through a cafeteria plan. This provision was effective the day that the bill was signed, and for most employers, went into effect on March 1, 2009. Employers were required to send notice of the subsidy to eligible employees and former employees by April 18th.

This document provides an overview of the COBRA subsidy process, specifics on identifying eligible individuals, and steps on how to ensure all necessary process are in place in your organization.

OVERVIEW OF THE COBRA SUBSIDY PROCESS

There are a number of steps involved in ensuring compliance with the COBRA provisions of the Stimulus Act. They include:

- Identifying all individuals eligible for the subsidy
- Sending updated notices to all eligible individuals by April 18th
- Maintaining appropriate records in order to file for the tax credit for the 65 percent subsidy on federal payroll tax Form 941
- Ensuring that processes are in place for collecting the 35 percent premium, refunding overpayments of recent premiums (if any), and notifying eligible individuals when their nine month subsidy period has concluded

The remainder of this document will discuss each step in more detail. At the end of this guide, you can find the documents that will assist you in this process.

IDENTIFYING ASSISTANCE ELIGIBLE INDIVIDUALS

Who Qualifies for the 65 percent COBRA Premium Subsidy?

To be eligible for the 65 percent COBRA premium subsidy, the employee:

- Must have been COBRA eligible (or continuation coverage eligible under Maryland law) prior to February 17th (i.e. covered by the employer's health insurance plan- for at least three months if fewer than 20 employees- and not terminated for gross misconduct); and
- Lost his or her job *involuntarily* between September 1, 2008 and February 17th, 2009 (eligible individuals in this group include those who didn't sign up for COBRA or who signed up for COBRA but let the coverage lapse); or
- Will lose or have *involuntarily* lost their jobs between February 18th and December 31, 2009;
- Eligible individuals include covered spouses and dependents of those who *involuntarily* lost or will lose their jobs.

IRS Notice 2009-27 defines an *involuntary termination* as “a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services.” An “employee-initiated” termination could also be considered involuntary if it is a termination for good reason due to employer action that causes a “material negative change in the employment relationship for the employee.” The Notice does not define “material negative change.” Notice 2009-27 also provides that a layoff with recall rights or a temporary furlough (i.e., a reduction in hours to zero) will be considered an “involuntary termination” for purposes of the COBRA subsidy. For

further information regarding the term *involuntary termination* see Notice 2009-27 at: <http://www.irs.gov/pub/irs-drop/n-09-27.pdf>

Who is Disqualified for the 65 percent COBRA Premium Subsidy?

The 65 percent COBRA subsidy need not be provided if:

- The former employee became eligible for insurance under another group contract, HMO, or self-insured group program;
- The former employee became covered under a non-group policy or a non-group HMO;
- The former employee became covered by Medicare;
- The former employee elects not to be covered; or
- The former employer ceases to provide benefits under a group policy.

In addition, a high income individual (one who makes more than \$125,000 or a couple who makes more than \$250,000) will have all or part of the subsidy recaptured by the IRS through an increased tax liability. Even if the former employee or dependents are not eligible for the COBRA subsidy, they should still be provided with the notification described below.

NOTIFICATION

Notifying an Assistance Eligible Individual

Now that you have determined who is eligible for the premium subsidy and calculated how much the eligible individual owes for premiums starting as of the first coverage period beginning after February 17th, you must send the eligible individual proper notification of this new assistance and the forms that allow the eligible individual to apply for COBRA coverage and the 65 percent subsidy. You can find those forms at the IRS and Department of Labor websites at: <http://www.dol.gov/ebsa/COBRAmodeInotice.html> These forms are also available at the end of this publication.

The forms and notices include:

- A Model COBRA Continuation Election Notice
- A Model COBRA Continuation Election Notice (Abbreviated Version)
- COBRA Continuation Election Form
- Form For Switching COBRA Continuation Coverage Benefit Options (this form is only for use if you are allowing eligible individuals to enroll for different coverage than that under which s/he was covered at the time of the qualifying event)
- Summary of COBRA Premium Reduction Provisions Under ARRA
- Application For Request For Treatment As An Assistance Eligible Individual
- Application for Dependent Information
- Form For Notifying Former Employer That Former Employee Has Become Eligible For Other Group Health Coverage or Medicare

How Much Does the Employee Owe?

The COBRA assistance period takes effect as of the first coverage period beginning after February 17th. Accordingly, most employers will have to begin offering the subsidy as of March 1, as most health insurance plans offer coverage beginning at the start of each month. If you have not begun offering the subsidy, you can refund the amount of the subsidy to eligible individuals or credit their accounts against future payments.

For example, if an eligible individual's COBRA premium cost \$400.00 a month, the eligible individual would be expected to pay \$140, or 35 percent of the \$400.00 premium. If the eligible individual has already paid \$400 for the months of March and April, you owe the eligible individual \$520: \$260 (the 65 percent premium subsidy) x 2 months' premium. You can credit that amount against future COBRA premium payments or refund the excess premium payment to the eligible individual. There is no requirement to choose one method or the other.

MAINTAIN APPROPRIATE RECORDS

Filing for the Tax Credit Using Form 941

In effect, the federal government is using employers, plan administrators and insurance companies to act as the government's conduit in paying for the COBRA premium subsidy. The former employee pays 35 percent for the insurance coverage premium, but the employer pays the full amount of the premium to the health insurance carrier for the former employee's coverage. The federal government then reimburses the employer when the employer takes a credit for the subsidized amount against the next federal payroll tax deposit liability.

For example, if an eligible individual's COBRA premium cost \$400.00 a month, the eligible individual would be expected to pay \$140, or 35 percent of the \$400.00 premium. The eligible individual remits payment to the employer of \$140.00. The employer pays the insurer for the full premium of \$400, including the 65 percent subsidy of \$260.00. When the employer makes its next payroll tax deposit, the employer reduces its deposit by \$260.00, claiming a credit for that amount on IRS Form 941.

IRS Form 941 is the payroll tax form that employers are required to file once a quarter. The form has been revised to allow employers to note the subsidized amount it has paid for former employee's COBRA premiums. See: <http://www.irs.gov/pub/irs-pdf/f941.pdf>

Note that Lines 12a and 12b request information about the amounts paid for COBRA subsidies.

Employers who use a payroll service most likely have the payroll service file the Form 941. Payroll service providers have developed specific steps for their customers to follow in order to record and obtain credit for their subsidized premium payments.

In some instances, small group health insurers are establishing different methods for handling the subsidy process. At least one Maryland insurer has stipulated that "if you're a Maryland employer group with under 20 employees and you have former employees who qualify and select Mini-COBRA, you will receive a separate invoice for that membership.

The invoice for those former employees electing Mini-COBRA will be billed at 100% of the premium. However, you are only required to pay 35% of the premium for those involuntarily terminated former employees who are eligible for premium assistance, which is calculated by multiplying the invoice amount

for those individuals by .35. For example, if the monthly premium is \$200, take $\$200 \times .35 = \70 . Remit \$70. Continue this process with each month's billing. Subsequent invoices for Mini-COBRA will reflect an adjustment equal to the remaining 65% of the Mini-COBRA premium. Please note that you are still required to pay 100% of the premium for any former employees and their eligible dependents who qualify for Mini-COBRA but are not eligible for the premium subsidy.” Make sure that you check with your insurer to determine the method the organization will use for handling the subsidy.

ENSURE ALL NECESSARY PROCESSES ARE IN PLACE

Collection of the 35 percent Premiums

The employer is typically responsible for collecting the premium for former employees who are availing themselves of COBRA coverage. While there is no special form for noting such payments, a chart has been created that may be helpful to record all of the information you will need to keep track of the payments, the subsidized amounts, and the dates when the subsidy concludes (available to members of Maryland Nonprofits).

The employer should also keep the following information:

- Copies of checks received from the employee for the 35 percent premium, including dates and amounts received;
- If the employer has an insured plan, keep copies of the insurer's invoices indicating payment of the full premiums and the date of the payments;
- If the employer has a self-insured plan, keep copies of the premium amount and proof that the eligible individual was fully covered;
- Any documentation that attests to the involuntary termination and the date of that termination (e.g. a termination letter, a COBRA notice, an exit interview, final paperwork on the employee);
- Documentation that proves the individual was eligible for COBRA coverage during the covered period-September 1, 2008 to December 31, 2009;
- The eligible employee's social security number;
- The amount of the subsidy the employer reimbursed the employee and whether the subsidy was for 1, 2 or more people under the eligible person's coverage; and
- Any other documents the employer received that could verify the reimbursement amount.

Refunding Overpayments

Remember, the employer is responsible for refunding overpayments or properly crediting them to the former employee's account. This can be noted on the chart you are keeping for each former employee.

Notifying Eligible Individuals that their Nine Month Subsidy Period Has Ended

Keep information about the former employee's subsidy period on a chart or in a tickler file so you don't forget when the period has ended. If you continue to pay the subsidy amount when the period is over, you may have trouble collecting the full amount from the former employee.

ATTACHMENTS

- Model COBRA Continuation Election Notice
- COBRA Continuation Election Form
- Important Information about your Continuation Coverage Rights
- Summary of COBRA Premium Reduction Provisions Under ARRA
- Application For Request For Treatment As An Assistance Eligible Individual
- Application for Dependent Information

Sample chart for tracking COBRA coverage in your organization available to members of Maryland Nonprofits as a downloadable Word document in the members-only section of our website at www.marylandnonprofits.org.



Model Continuation Coverage Election Notice

(For use where coverage is subject to State continuation requirements during the period that begins with September 1, 2008 and ends with December 31, 2009.)

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the Continuation Coverage Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

If you do not elect continuation coverage, your coverage under the Plan will end on [enter date] due to [check appropriate box(es)]:

- End of employment
 - Involuntary
 - Voluntary

[Add any other events that would give rise to a right to continuation coverage under state law, such as

- Divorce or legal separation
- Death of employee
- Entitlement to Medicare
- Reduction in hours of employment
- Loss of dependent child status]

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [enter appropriate timeframe]

[Add appropriate categories and check appropriate box or boxes. Categories may include

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage

- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan]

If elected, continuation coverage will begin on [enter date] and can last until [enter date].

[Add, if appropriate: You may elect any of the following options for continuation coverage: [list available coverage options].

[If the issuer permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred, insert: “To change the coverage option(s) for your continuation coverage to something different than what you had on the last day of employment, complete the “Form for Switching Continuation Coverage Benefit Options” and return it to us. Available coverage options are: [insert list of available coverage options].” The different coverage must cost the same or less than the coverage the individual had at the time of the qualifying event; be offered to active employees; and cannot be limited to only dental coverage, vision coverage, counseling coverage, a flexible spending arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic.]

Continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods]. If you qualify as an “Assistance Eligible Individual” this cost can be reduced to [include the amount that is 35 percent of the amount above for each option] for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact [enter name of party responsible for continuation coverage administration for the issuer, with telephone number and address].

COBRA Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under [insert applicable law], you have [insert number of days] after the date of this notice to decide whether you want to elect continuation coverage.

Send completed Election Form to: *[Enter Name and Address]*

This Election Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage in the *[enter name of plan]* (the Plan) as indicated below:

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

[Add if appropriate: Coverage option(s): _____]

b. _____

[Add if appropriate: Coverage option(s): _____]

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number



[Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.]

Form for Switching Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your continuation coverage to something different than what you had on the last day of employment, complete this Form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options. Send completed Form to: [Enter Name and Address] This Form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than [enter date]. *THIS IS NOT YOUR ELECTION NOTICE* YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR CONTINUATION COVERAGE.

I (We) would like to change the continuation coverage option(s) in the [enter name of plan] (the Plan) as indicated below:

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

a. _____

Old Coverage Option: _____

New Coverage Option: _____

b. _____

Old Coverage Option: _____

New Coverage Option: _____

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number



Important Information about Your Continuation Coverage Rights

What is continuation coverage?

Maryland's continuation coverage regulations are "applicable to all group health policies or contracts issued or delivered in the State to the employer of the insured which provide hospital, surgical, medical, or major medical benefits on an expense-incurred basis..." *Code of Maryland Regulations* 31.11.04.03. Under Maryland law, employers must offer up to 18 months of continuation coverage to all employees who meet the definition of "Insured" and experience an "Applicable Change in Status". *Code of Maryland Regulations* 31.11.04.02. An "Insured" is an employee who is a resident of the State and covered under a group policy for at least three months. Applicable Change in Status is defined as "the termination of the insured's employment other than for cause." The term includes:

- Involuntary termination of the insured's employment other than for cause; and
- Voluntary termination of the insured's employment by the insured.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [add if applicable: open enrollment and] special enrollment rights.]

How long will continuation coverage last?

Continuation coverage ends after 18 months, or earlier for any of the following reasons:

- For not making payments on time
- If the individual becomes eligible for coverage under another group expense incurred medical insurance policy or HMO
- If the individual becomes entitled to benefits under Medicare
- If the individual becomes covered under a non-group expense-incurred medical insurance policy or HMO
- If the individual terminates the coverage
- If the employer no longer offers any group health benefit plan.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form within 45 days. In the event of a divorce or death of the insured, a covered spouse and/or dependent must be offered continuation coverage if the insured is covered by a group contract at the time of the qualifying event.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

[Insert general information regarding the cost of continuation coverage.]

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the continuation coverage premium otherwise due to the issuer. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the Continuation Coverage Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

[If employees might be eligible for trade adjustment assistance, the following information must be added: The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80 percent of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.]

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.]

When and how must payment for continuation coverage be made?

[Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]

You may contact *[enter appropriate contact information for the party responsible for continuation coverage administration under the Plan]* to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Your payment(s) for continuation coverage should be sent to:*[enter appropriate payment address]*

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from *[enter appropriate contact information for the party responsible for continuation coverage administration under the Plan]*.

If you have any questions concerning the information in this notice, your rights to coverage you should contact *[enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address]*.

For more information about your rights under state law, contact *[insert appropriate contact information.]*

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep *[enter name and contact information for the appropriate party responsible for continuation coverage administration under the Plan]* informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to *[enter the name of the party responsible for continuation coverage administration under the Plan]*.

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an Assistance Eligible Individual and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.*

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding continuation coverage you can contact [*enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address*].

For specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, contact [*enter name of party responsible for ARRA Premium Reduction administration for the Plan, with telephone number and address*].

If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

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 Continuation Coverage Premium Reduction Provisions Under ARRA."

[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)

To qualify, you must be able to check 'Yes' for all statements.

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 December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not 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
5. I am NOT eligible for Medicare (or I was not 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 ISSUER USE ONLY

This application is: Approved Denied Approved for some/denied for others (explain in #4 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 December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect continuation coverage.	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

Signature of party responsible for continuation coverage 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) 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) 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) 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 issuers to distribute to qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the issuer if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your issuer that you are eligible for other group health plan coverage or Medicare.

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 issuer of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced continuation coverage premiums you could be subject to a fine of 110 percent 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:

_____	_____
_____	_____

