# APPLICATION FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Plan Administrator:

Mailing Address: Telephone Number:

**Application Procedures:** To apply for ARRA Premium Reduction, complete this form and return it along with your Election Form. You may also send this form in separately. Send to the Plan Administrator at the address listed above. Please read all the information contained in your qualifying event notification packet or call the above telephone number if you need any additional information.

## PERSONAL INFORMATION

| Name and address of employee (list other qualified beneficiaries on the back of this fom. | Telephone number |
|---|---|
| | E-mail address (optional) |

**To qualify, you must be able to answer "Yes" for all statements.**

| | |
|---|---|
| 1. The qualifying event was an involuntary termination of employment or a reduction in hours FOLLOWED by an involuntary termination of employment. (Involuntary termination does NOT include death of the employee.) | ☐ Yes ☐ No |
| 2. The involuntary termination of employment occurred at some point on or after September 1, 2008 and on or before May 31, 2010. | ☐ Yes ☐ No |
| 3. The qualifying event was **NOT** the death of the employee, divorce, legal separation, or dependent ceasing to be a dependent under the terms of the group health plan. | ☐ Yes ☐ No |
| 4. I elected (or am electing) group health insurance continuation coverage (COBRA). | ☐ Yes ☐ No |
| 5. I am **NOT** eligible for other group health plan coverage, including plan coverage provided by a spouse's employer group health plan (or I was not eligible for other group health coverage during the period for which I am claiming a reduced premium). | ☐ Yes ☐ No |
| 6. I am **NOT** eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium. | ☐ Yes ☐ No |

## ELECTION OF ARRA PREMIUM REDUCTION AND ACKNOWLEDGEMENT OF MY RESPONSIBILITY TO NOTIFY THE PLAN ADMINISTRATOR OF LOSS OF ELIGIBILITY FOR ARRA PREMIUM REDUCTION

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 accurate.

I understand that if I have misrepresented the facts on this form, I may be subject to Internal Revenue Service (IRS) penalties. I also understand that it is my responsibility to notify the plan administrator immediately by using the attached notification form if I lose eligibility for ARRA Premium Reduction by becoming eligible for other group health plan coverage or Medicare.

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 #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.The qualifying event was NOT an involuntary termination of employment. | ☐ |
| 2.The involuntary termination of employment did NOT occur between September 1, 2008 and May 31, 2010. | ☐ |
| 3.The qualified beneficiary did NOT elect continuation coverage. | ☐ |
| 4.Other (please explain) | ☐ |

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

Signature _____ Date _____

Type or print name _____

Telephone number _____ E-mail address _____

**ADDITIONAL QUALIFIED BENEFICIARIES - 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) group health insurance continuation coverage (COBRA). | ☐ Yes ☐ No |
| 2. I am **NOT** eligible for other group health plan coverage. | ☐ Yes ☐ No |
| 3. I am **NOT** eligible for Medicare. | ☐ Yes ☐ 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 accurate.

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) group health insurance continuation coverage (COBRA). | ☐ Yes ☐ No |
| 2. I am **NOT** eligible for other group health plan coverage. | ☐ Yes ☐ No |
| 3. I am **NOT** eligible for Medicare. | ☐ Yes ☐ 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 accurate.

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) group health insurance continuation coverage (COBRA). | ☐ Yes ☐ No |
| 2. I am **NOT** eligible for other group health plan coverage. | ☐ Yes ☐ No |
| 3. I am **NOT** eligible for Medicare. | ☐ Yes ☐ 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 accurate.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

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

D. _____

| | |
|---|---|
| 1. I elected (or am electing) group health insurance continuation coverage (COBRA). | ☐ Yes ☐ No |
| 2. I am **NOT** eligible for other group health plan coverage. | ☐ Yes ☐ No |
| 3. I am **NOT** eligible for Medicare. | ☐ Yes ☐ 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 accurate.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

# Notification To Plan Administrator of Eligibility for Group Health Insurance or Medicare Eligibility

## Other Group Health Plan Coverage or Medicare

As an assistance eligible individual (AEI) you have been approved for premium reduction for a maximum period of 15 months. However, this is not a guarantee of 15 months. Your application was approved because you affirmed you are not eligible for other group health plan coverage or Medicare. If, however, during this 15 month period, you, or a dependent, do become eligible for other group health plan coverage or Medicare, your rights to reduced premium will cease.

## USE THIS FORM TO NOTIFY THE PLAN ADMINISTRATOR OF YOUR PLAN ELIGIBILITY!

Eligibility for other group health coverage or Medicare does NOT terminate your group health insurance continuation coverage, it only terminates your reduced premium. You can maintain your group health insurance continuation coverage by paying the full 102% of the applicable premium as described in your election information. Should you need premium information, please call:

**IMPORTANT NOTICE REGARDING POTENTIAL INTERNAL REVENUE SERVICE (IRS) 110% FINES FOR FAILURE TO NOTIFY**

If you fail to notify the plan administrator of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced premiums, you could be fined by the IRS in the amount of **110%** of the premium reduction. Eligibility is determined regardless of whether you take or decline the other group health plan coverage. However, if you enroll in another group health plan, but are subject to a waiting period (ie; 30, 60, 90 days) before coverage begins, the time spent in a waiting period will not cancel your premium reduction.

## MAILING OR FAX INSTRUCTIONS TO PLAN ADMINISTRATOR

After completion, please make a copy of the form for your records and mail or fax the form to the following:

Plan Administrator:
Address:
Telephone #:
FAX Number #:
E-mail:

## PERSONAL INFORMATION

Your Name and Mailing Address

Telephone Number

## PREMIUM REDUCTION INELIGIBILITY INFORMATION - Check One

☐ I am **eligible for coverage under another group health plan**, or I have enrolled in another group health plan and the waiting period is over. If any dependents receiving premium reduction are also eligible, include their names below.

Insert date you became eligible: _____

You MUST list the names of the dependents that are also eligible for other group health plan coverage:

_____ _____

_____ _____

☐ I am eligible for **Medicare**.

Insert date you became eligible for Medicare: _____

## Signature and Affirmation

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

Signature _____ Date _____

Type or print name _____