



REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

To apply for ARRA Premium Reduction, complete this form and return it to your former employer along with your completed continuation election form(s). If you are changing coverage type or plan options, you will also need to submit a completed application form.

If you are electing continuation coverage for any of the optional plans, such as dental, you must complete and submit a separate continuation election form for each plan you wish to continue.

Section A: PERSONAL INFORMATION FOR EMPLOYEE - List dependent information on back.

Name of Employee (First Name, Middle Initial, Last Name)	Employee's Social Security Number
Mailing Address	Telephone Number
Email Address	

Section B: QUALIFICATION - 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 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.	<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 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
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).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section C: SIGNATURE OF APPLICANT

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 USE ONLY – Return copy of completed form to the applicant

Date Employment Terminated _____
 Coverage(s) in effect at time of termination: Health Anthem DentalBlue Vision Insurance EPIC
 Other _____
 This application is: Approved Denied Approved for some/denied for others (explain in #4 below)

IF DENIED, 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 _____



Section D: DEPENDENT INFORMATION – If applying for family coverage, complete the information for each eligible dependent. Attach additional copies of this form if you have more than 4 eligible dependents. (Parent or guardian should sign for minor children.)

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
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 _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
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 _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
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 _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
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 _____	