

## COBRA & Continuation Election Notice (Full Version)

**Instructions: Pages 1-7 to be completed by group prior to giving notice and forms to the employee.  
Pages 9-12 only to be completed by the plan administrator and employee and returned to  
BCBSM, P.O. Box 64024, St. Paul, MN 55164 or return it via fax to 1-651-662-2745.**

Date: \_\_\_\_\_

Dear: \_\_\_\_\_  
*[Identify the qualified beneficiary(ies), by name]*

**This notice contains important information about your right to continue your health care coverage in the plan.**

\_\_\_\_\_ *[enter name of employer]* 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 COBRA continuation coverage, complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on \_\_\_\_\_ due to: (enter date)

- |  |   |
|--|---|
| <input type="checkbox"/> End of employment (18 months)               | <input type="checkbox"/> Reduction in hours of employment (18 months) |
| <input type="checkbox"/> Active military service (24 months)         | <input type="checkbox"/> Divorce (36 months or indefinite)            |
| <input type="checkbox"/> Death of employee (36 months or indefinite) | <input type="checkbox"/> Loss of dependent child status (36 months)   |
| <input type="checkbox"/> Entitlement to Medicare (36 months total)   |   |

Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to \_\_\_\_\_ months *[enter 18, 36, or indefinite as appropriate and check appropriate box or boxes]:*

**Relationship:**

- 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

**Name:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If elected, COBRA continuation coverage will begin on \_\_\_\_\_ and can last until \_\_\_\_\_  
*[enter date]* *[enter date]*

You may elect any of the following options in which you are already enrolled for COBRA continuation coverage:

Health       Dental

COBRA continuation coverage will cost:

<b>Health:</b>		<b>Dental:</b>	
Single	_____	Single	_____
Family	_____	Family	_____

If you qualify as an “Assistance Eligible Individual” this cost can be reduced to the amounts shown below for up to nine months.

<b>Health:</b>		<b>Dental:</b>	
Single	_____	Single	_____
Family	_____	Family	_____

*[Self-insured employers - delete the following section if you do not allow coverage changes]*

**To change the coverage option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment, complete the “Form for Switching COBRA Continuation Coverage Benefit Options” and return it to us.**

**Available coverage options and the associated costs are:**

:

<b>Health:</b>		<b>Dental:</b>	
Single	_____	Single	_____
Family	_____	Family	_____

If you qualify as an “Assistance Eligible Individual” this cost can be reduced to the amounts shown below for up to nine months.

<b>Health:</b>		<b>Dental:</b>	
Single	_____	Single	_____
Family	_____	Family	_____

You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact: \_\_\_\_\_

*[enter name of party responsible for COBRA administration for the Plan, with telephone number & address]*

**IMPORTANT INFORMATION**  
**ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS**

**What is continuation coverage?**

Federal law and Minnesota law require that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

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 open enrollment and special enrollment rights.

**How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. However, if a loss of employment or reduction in hours occurs as a result of active military service, coverage may be continued for up to 24 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

For fully insured plans, Minnesota law permits an indefinite period of continuation when the qualifying event is the employee’s death or divorce. In these two circumstances continuation will continue until:

- 1) such time as the group ceases offering group health coverage to any employees;
- 2) the qualified beneficiary fails to pay the required premium;
- 3) coverage of the qualified beneficiary is terminated for cause (e.g. submitting fraudulent claims.);
- 4) enrollment in other group coverage.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage except for fully insured plans under Minnesota law, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

## **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify

\_\_\_\_\_ of a disability or a second qualifying event  
*[enter name of party responsible for COBRA administration]*  
in order to extend the period of continuation coverage. Failure to provide notice of a disability or a second qualifying event may affect the right to extend the period of continuation coverage.

### *Disability*

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time on or before the 60<sup>th</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Under Minnesota State law, the employee is considered disabled for the first 24 months if he or she is unable to perform their regular duties, even without a Social Security Administration disability determination. After 24 months, a disabled employee may stay on the plan as long as they are unable to engage in any paid employment. While only the employee's disability is considered, eligible dependents may also continue coverage.

### *Second Qualifying Event*

An 18-month extension of coverage, upon the occurrence of a second qualifying event, is available to spouses and dependent children who elect continuation coverage if the first qualifying event is a loss of employment or a reduction in hours and a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months (or longer for fully insured plans under Minnesota law). Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

## **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

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 pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you -prevent such a gap. Second, you will lose the guaranteed right to purchase individual health -coverage that does not impose such pre-existing condition exclusions 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 COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. An employee who continues under the disability provisions of Minnesota law may be charged up to the cost to the employer only. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA 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 COBRA premium otherwise due to the plan. 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 COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

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 these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% 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% 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 tax 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/](http://www.doleta.gov/tradeact/).

### **When and how must payment for COBRA continuation coverage be made?**

#### *First payment for continuation coverage*

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage **in full** not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

You may contact \_\_\_\_\_  
[enter appropriate contact information for COBRA administration under the Plan]

to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

*Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the

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*[enter due day for each monthly payment]*

for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

*Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

**If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.**

Your first payment and all periodic payments for continuation coverage should be sent to:

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*[enter appropriate payment address]*

**Life Insurance Continuation of Coverage**

(This section applies to covered employees only.)

A covered employee who is voluntarily or involuntarily terminated or laid off from their employment may elect to continue their coverage, including that of any dependents. An employee is considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible for coverage under the group life insurance policy. Termination does not include discharge for gross misconduct.

As a terminated or laid off employee, the law authorizes you to maintain your group insurance benefits, in an amount equal to the amount of insurance in effect on the date you terminated or were laid off from employment, until you obtain coverage under another group policy, or for a period of up to 18 months, whichever is shorter. To do so, you must notify \_\_\_\_\_ within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of \$ \_\_\_\_\_ at \_\_\_\_\_ by the \_\_\_\_\_ of each month.

**For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact

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*[enter name of party responsible for COBRA administration for the Plan, with telephone number & address]*

Private sector employees seeking more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, may contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). State and local government employees should contact HHS-CMS at [www.cms.hhs.gov/COBRAContinuationofCov/](http://www.cms.hhs.gov/COBRAContinuationofCov/) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).

**Keep Your Plan Informed of Address Changes**

In order to protect your and your family's rights, you should keep the Plan Administrator 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 the Plan Administrator.

# 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.\*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

## ◆ 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](http://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](http://www.cms.hhs.gov/COBRAContinuationofCov) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov)

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\* 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.

**COBRA CONTINUATION COVERAGE ELECTION / WAIVER FORM**

**INSTRUCTIONS:** To elect COBRA continuation coverage, complete this Election Form and return it to us. Under Federal law, you must have 60 days after the date of this notice, or from the date your health coverage ends, whichever is later, to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to:

\_\_\_\_\_ *[Enter Name and Address]*

This Election Form must be completed and returned by mail. 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 COBRA continuation coverage. If you reject COBRA 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 COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included with the Election Form.

**COVERAGE ELECTION/WAIVER**

Please indicate whether you wish to continue your coverage. Your signature is required whether you elect to continue coverage or not. The signature of a parent or guardian is binding for any dependent under age 18.

I (We) elect/waive COBRA continuation coverage in the \_\_\_\_\_ (Plan) as indicated below:  
*[enter name of employer]*

Name	Member ID. No.	Relationship	Health	Dental	Life	Primary Care Clinic No. (Blue Plus Only)
			Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	

\_\_\_\_\_  
Signature and relationship to employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

**Plan Administrator/Employer: Please complete information in the box below.**

Employee Name: _____	Member Identification Number _____
COBRA Start Date: _____	COBRA End Date: _____
Qualifying Event: _____	Date of Qualifying Event: _____
Group Numbers: Health _____	Dental _____
Approved by: _____	Life _____
	Date _____

Employer/Plan Administrator: **Please return this page, the coverage change page, if applicable, and the Request for Treatment as an Assistance Eligible Individual pages of the form** (if member is electing coverage) **via mail** to: BlueCross and BlueShield of Minnesota, P.O. Box 64024, St. Paul, MN 55164 or **via fax** to: 1-651-662-2745. Please retain a copy for your records. Do not return this form to us if member is waiving coverage.

FORM FOR SWITCHING COBRA CONTINUATION COVERAGE BENEFIT OPTIONS

Instructions: To change the benefit option(s) for your COBRA 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 Election Form must be completed and returned by mail. 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 COBRA CONTINUATION COVERAGE.**

I (We) would like to change the COBRA 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: \_\_\_\_\_

c. \_\_\_\_\_

Old Coverage Option: \_\_\_\_\_

New Coverage Option: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

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

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."

Plan/Employer Name:

**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

Plan/Employer 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 EMPLOYER 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"/>

**Employer Attestation: I hereby attest that during the calendar year 2008**

- this employer normally employed **fewer than 20 employees** on a typical business day and is subject to Minnesota continuation laws.
- this employer normally employed **20 or more employees** on a typical business day and is subject to federal COBRA laws.

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 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 issuer that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.**

Plan Name	<b>Participant Notification</b>	Plan Mailing Address
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**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 _____	<input type="checkbox"/>
I am eligible for Medicare.  Insert date you became eligible _____	<input type="checkbox"/>

**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% 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:
