CONTINUATION OF HEALTH BENEFITS COVERAGE UNDER COBRA

STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

ASSISTANCE ELIGIBILITY REQUEST FORM

To apply for ARRA Premium Reduction, complete this form and return it to us along with your *COBRA Application*. If you are already enrolled in COBRA, only send this form. If you choose to do so, send the completed *Assistance Eligibility Request* form to:

The Division of Pensions and Benefits PO Box 299 Trenton, NJ 08625-0299

You may also want to read the important information about eligibility criteria and your rights included in the *"Summary of the COBRA Premium Reduction Provisions Under ARRA."*

PERSONAL INFORMATION

Employee Name: _____ **Telephone Number:** _____

Employee Address: _____ **E-mail address (optional):** _____

_____

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

1. The loss of employment was involuntary. ❒ **YES** ❒ **NO**
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before May 31, 2010. ❒ **YES** ❒ **NO**
3. I elected (or am electing) COBRA continuation coverage.* ❒ **YES** ❒ **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). ❒ **YES** ❒ **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). ❒ **YES** ❒ **NO**

***If you checked "NO" for Statement #3, you may still be eligible. See below for more information.**

***Extension Period**

Assistance eligible individuals whose continuation coverage was discontinued following the expiration of their nine-month subsidy period have the right to pay back premiums and be retroactively reinstated. To qualify for reinstatement, the individual should contact the Health Benefits Bureau of the Division of Pensions and Benefits immediately to arrange for the payment on any back premiums.

Assistance eligible individuals who maintained continuation coverage by paying the full COBRA premium after the nine-month subsidy period will have their COBRA bill adjusted to reflect the subsidy amount. Individuals who reached the end of the reduced premium period before the subsidy extension will receive a credit for any overpayment due on a future bill.

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: _____

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. ❒
2. The involuntary loss did not occur between September 1, 2008 and May 31, 2010. ❒
3. Individual did not elect COBRA coverage.* ❒
4. Other (please explain) ❒

***If individual checked number 3, was the individual eligible for the Extension Period described above? ❒ YES ❒ NO**

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: _____