[Carrier letterhead/logo]

New Jersey Continuation Coverage
Notice of Continuation Option and Election for Premium Reduction

[Date][Or, if a carrier wants to make this a generic piece, omit the date]

Dear Former Employee: *[Carriers may include employee name or may leave as generic]*

This notice contains important information about your option to continue your medical coverage under your former employer's group health benefits plan. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation premium in some cases. According to information we received from your former employer, your medical coverage terminated between September 1, 2008 and the present. You may be eligible for a temporary ARRA 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 attachments very carefully.

Involuntary Termination of Employment between September 1, 2008 and April 18, 2009
*If coverage terminated and New Jersey Continuation **is not** already in effect*

If you think you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed New Jersey Continuation Election Form to your former employer along with the Employer Information and Verification form. The application and election form must be completed *within 30 days* of the date you receive this notice. Coverage will be effective as of the beginning of the first period of coverage on or after February 17, 2009. For example, if your former employer's plan uses a period of coverage that runs from the 1st of the month, your continuation coverage will begin as of March 1, if the period of coverage runs from the 15th of the month, your continuation coverage will begin as of March 15. The premium reduction will commence as of that same date and will last no more than 9 months. The 18-month period for New Jersey Continuation will be measured from the date of your prior loss of coverage.

If your former employer offers more than one medical plan option to active employees, you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or less than the cost for the plan you had when your coverage ended. Check with your former employer regarding alternate options and the cost for such options. The election for the alternate plan must be noted on the New Jersey Continuation Election Form and the Form for Switching Plan Options must be attached.

You will be required to pay the first premium which will cover the period from the date continuation coverage begins through the current period *within 30 days* of the date you make the election. Send all premium payments to your former employer who will add such payments to the premium being sent to us (the carrier) for the coverage for active

employees. If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. *[Specific premium information is enclosed.] [Carriers, if it is not enclosed, say how the former employee can get it]*

Involuntary Termination of Employment between September 1, 2008 and April 18, 2009
*If coverage terminated and New Jersey Continuation **is** already in effect*

If you are already covered under New Jersey Continuation it is not necessary to complete another Continuation Election Form. You must, however, complete the "Application for Treatment as an Assistance Eligible Individual" within 30 days of the date you receive it if you wish to be considered for the premium reduction. Mail the completed application to your former employer along with the Employer Information and Verification form. The premium reduction will be effective as of the beginning of the first period of coverage on or after February 17, 2009. For example, if your former employer's plan uses a period of coverage that runs from the 1st of the month, your premium reduction will be effective as of March 1, if the period of coverage runs from the 15th of the month, your premium reduction will begin as of March 15. In no event will the premium reduction be effective for a period prior to the date coverage ended. March and/or April Premiums that may already have been paid in full will be refunded or credited. The premium reduction will last no more than 9 months. Such 9-month premium reduction period neither extends nor reduces the 18 months available for New Jersey Continuation.

If your former employer offers more than one medical plan option to active employees you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or less than the cost for the plan you had when your coverage ended. Check with your former employer regarding alternate options and the cost for such options. The election for the alternate plan must be specified on the Form for Switching Plan Options. Return this form *within 30 days* of receipt of this notice. The coverage under the new plan will be effective as of the start of the first period of coverage on or after the form is received.

If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. Since you will already have paid the March and April New Jersey Continuation premiums in full, you will receive a refund or a credit for the excess payments for March and April.

Involuntary Termination of Employment between April 19, 2009 and December 31, 2009

If you think you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and mail it with your completed New Jersey Continuation Election Form to your former employer. *Both* must be completed *within 30 days* of the date you receive this notice. Your mailing to the former employer must also include the Employer Information and Verification Form. Coverage will be effective as of the day after your coverage ended, meaning there will be no break in coverage. The premium reduction will last no more than 9 months. Such 9-month

premium reduction period neither extends nor reduces the 18 months available for New Jersey Continuation.

If your former employer offers more than one medical plan option to active employees you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or less than the cost for the plan you had when your coverage ended. Check with your former employer regarding alternate options and the cost for such options. The election for the alternate plan must be noted on the New Jersey Continuation Election Form and the Form for Switching Plan Options must be attached

You will be required to pay the first premium which will cover the period from the date continuation coverage begins through the current period *within 30 days* of the date you make the election. Send all premium payments to your former employer who will add such payments to the premium being sent to us (the carrier) for the coverage for active employees. If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. *[Specific premium information is enclosed.] [Carriers, if it is not enclosed, say how the former employee can get it]*

Mail these completed forms to your former employer.

- ✓ New Jersey Continuation Election Form (if you are electing continuation now)
- ✓ Form for Switching Options (if you are electing another option)
- ✓ Request for Treatment as an Assistance Eligible Individual
- ✓ Employer Information and Verification

If you have any questions concerning an election for New Jersey Continuation or the premium reduction, please contact *[carrier member services at phone]*

Sincerely,
[Carrier]

New Jersey Continuation Election Form

For involuntary terminations of employment between September 1, 2008 and December 31, 2009

Instructions:
This Election Form can ONLY be used to elect New Jersey Continuation in the event of an *involuntary* termination of employment occurring between September 1, 2008 and December 31, 2009. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

To elect to continue medical coverage under New Jersey Continuation, the terminated employee must complete the following form and mail it to the former employer. The completed election form must be postmarked ***within 30 days*** of the date this notice was received.

If medical coverage under New Jersey Continuation is already in effect, do not complete this election form again.

I elect to continue medical coverage for myself and all dependents listed in item II below.

I. Terminated Employee Information

Name: _____ SS# _____
First MI Last or other identifier

Address _____
Street City State Zip Code

Dates: _____ _____
Employment Ended Medical Coverage Ended

Was the termination an involuntary termination of employment? ☐ Yes ☐ No

If No, do not submit this form. Contact your former employer for information on New Jersey Continuation.

II. Dependent Information

List all dependents who were covered under your former employer's medical plan on the date before your employment was involuntarily terminated and who you wish to cover under New Jersey Continuation. *Note*: Dependent coverage can ONLY be continued if the former employee elects to continue coverage for him/herself.

Name	Date of Birth	Relationship To employee	SS# or other identifier

III. Plan Selection

Check one

☐Same coverage that was in effect on the day before coverage ended or such other replacement coverage as is currently offered to active employees

☐Alternate coverage. You must complete the Form for Switching Plan Options

IV. Signature

_____ _____

Signature of Terminated Employee Date

Form for Switching Plan Options

For involuntary terminations of employment between September 1, 2008 and December 31, 2009

Instructions:

This Form for Switching Plan Options can ONLY be used if you have elected or are electing New Jersey Continuation following an *involuntary* termination of employment occurring between September 1, 2008 and December 31, 2009.

Contact your former employer and ask the following:

1. Does the employer offer a medical plan for active employees other than the plan under which you were covered prior to your termination of employment? If yes, proceed to item 2. If no, you have no opportunity to switch plan options.
2. Is the cost for the alternate plan the same or less than the cost for the plan under which you were covered prior to your termination of employment? If yes, proceed to item 3. If no, you have no opportunity to switch plan options.
3. Ask your former employer for the name of the carrier issuing the alternate plan, the exact plan name of the alternate plan along with information on the applicable copayments, deductible and coinsurance. If the employer is not sure of this information, suggest that he or she ask the broker for these details. The carrier will verify the availability of the alternate plan.

For new elections of New Jersey Continuation the alternate plan will be effective as of the effective date of continuation coverage.

If New Jersey Continuation is already in effect, the alternate plan will be effective as of the start of the first period of coverage on or after this election is received.

I elect New Jersey Continuation coverage for myself and my covered dependents under the alternate plan option as stated below.

I. Terminated Employee Information

Name: _____ SS# _____
First MI Last or other identifier

Address _____
Street City State Zip Code

Dates: _____ _____
Employment Ended Medical Coverage Ended

II. Alternate Plan Election

Name of carrier issuing alternate plan: _____

Name of alternate plan: _____

Copayment: _____ Deductible: _____ Coinsurance: _____

III. Signature

_____ _____
Signature of Terminated Employee Date

American Recovery and Reinvestment Act of 2009 (ARRA)
Employer Information and Verification

Dear Former Employer:

I received information from the insurance carrier regarding New Jersey Continuation coverage and have completed the "Request for Treatment as an Assistance Eligible Individual" The carrier also sent me this Employer Information and Verification to send to you to complete.

In order for the carrier to determine if I am eligible for the ARRA Premium Reduction please complete the following and return it to the carrier along with my Request for Treatment as an Assistance Eligible Individual and my continuation election form, if it is enclosed. Please complete and mail immediately so the carrier may process my request.

Please understand that your cooperation in providing this information will **not** result in you being required to pay the 65% reduction. The carrier will pay it. Without this information I may not be able to take advantage of the premium reduction. While the carrier and I anticipate you will cooperate, the New Jersey Department of Labor and Workforce Development has indicated it will take necessary action if an employer fails to cooperate. Further, if you fail to complete the Employer Information and Verification the carrier will deny my request for treatment as an assistance eligible individual which will entitle me to appeal rights with the U.S. Department of Health and Human Services.

Former Employee Name: _____
Employee fill in your name

To be completed by Former Employer

Date Employment Terminated: _____

Was the termination an *involuntary* termination of employment? ☐ Yes ☐ No
If no, the premium reduction is not available. Briefly describe the circumstances of the termination:
_____
_____

Date medical coverage terminated: _____

Do you currently offer group medical coverage to active employees? ☐ Yes ☐ No
If no, continuation is not available and neither is the premium reduction.

Has your company continuously maintained group medical coverage under our plan or under a succeeding carrier's plan since the date the employee was terminated? ☐ Yes ☐ No
If no, continuation is not available and neither is the premium reduction.

Do you offer more than one plan option to employees? ☐ Yes ☐ No
If yes, name the carriers and identify the other plans.

Carrier name	**Plan** (name and brief description)
_____	_____
_____	_____

Is your current group medical coverage issued by another carrier? ☐ Yes ☐ No
If yes, identify the carrier _____

If yes and your former employee was involuntarily terminated from employment between September 1, 2008 and December 31, 2009, please send a copy of this form to this other carrier at the address you currently use for new enrollments so the former employee may secure New Jersey Continuation coverage and the premium reduction under that carrier's plan.

_____	_____	
Employer – Signature	Date	
_____	_____	_____
Employer – Printed name	Telephone	E-mail

Instruction to Former Employer: Send this Employer Information and Verification form along with the New Jersey Continuation Election Form, if any, Form for Switching Plan Options, if any and the Request for Treatment as an Assistance Eligible Individual to *[carrier, address]*.

To apply for ARRA Premium Reduction, complete this form and send it to your former employer along with your Election Form if newly electing New Jersey Continuation. Also send the Employer Information and Verification form to your former employer.

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" along with the Employer Information and Verification to your former employer.

[*Insert Carrier Name*]	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	[*Insert Carrier 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.	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes	☐ No
3. I elected (or am electing) 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

I make an election to exercise my right to the ARRA Premium Reduction for myself and my eligible dependents. 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/print name → _____ Relationship to employee → _____

FOR CARRIER 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 December 31, 2009.

☐3. Individual did not elect continuation coverage.

☐4. Other (please explain)

Signature of party responsible for continuation coverage administration

→ _____ Date → _____

Type/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. The former employee elected (or is electing) continuation coverage.	☐ Yes	☐ No
2. I (the dependent) am NOT eligible for other group health plan coverage.	☐ Yes	☐ No
3. I (the dependent) am NOT eligible for Medicare.	☐ Yes	☐ No

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/print name→ _____ Relationship to employee → _____

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

b. _____

1. The former employee elected (or is electing) continuation coverage.	☐ Yes	☐ No
2. I (the dependent) am NOT eligible for other group health plan coverage.	☐ Yes	☐ No
3. I (the dependent) am NOT eligible for Medicare.	☐ Yes	☐ No

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/print name→ _____ Relationship to employee → _____

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

c. _____

1. The former employee elected (or is electing) continuation coverage.	☐ Yes	☐ No
2. I (the dependent) am NOT eligible for other group health plan coverage.	☐ Yes	☐ No
3. I (the dependent) am NOT eligible for Medicare.	☐ Yes	☐ No

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/print name→ _____ Relationship to employee → _____

This form is designed for issuers to distribute to New Jersey continuees who are paying reduced premiums pursuant to ARRA so they can notify the carrier if they become eligible for other group health plan coverage or Medicare.

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

[*Carrier Namei*]	**Participant Notification**	[*Carrier 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 carrier 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/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:

_____ _____

_____ _____