**To apply for ARP Premium Assistance, complete this form and return it to your plan or employer. If you have not yet elected COBRA continuation coverage, you may send this form along with your Election Form. If you do not complete this form and return it within 60 days of receipt, you may be unable to receive the premium assistance.**

**If you are already enrolled in COBRA, you may send this form in separately. If you choose to do so, send the completed “Request for Treatment as an Assistance Eligible Individual” to: [*Enter Name and Address*]**

**You may also want to read the important information about the rules for premium assistance included in the “Summary of the COBRA Premium Assistance Provisions Under the American Rescue Plan Act of 2021.”**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [*Insert Plan Name*] | **REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL** | | | [*Insert Plan 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 qualifying event was a loss of employment that was involuntary or a reduction in hours. | | | | | □ 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 premium assistance). | | | | | □ Yes □ No |
| 5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance). | | | | | □ Yes □ No |
|  | | | | | |
|  | | | | | |
| I make an election to exercise my right to ARP premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. 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 OR PLAN USE ONLY**  This request is: □ Approved □ Denied Specify reason in #3 below and 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. Individual did not experience a reduction in hours. | | | □ | | |
| 3. Individual did not elect COBRA coverage. | | | □ | | |
| 4. Other (please explain) | | | □ | | |
|  | | | | | |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

**For Further Assistance, you may contact the Department of Labor’s Employee Benefits Administration at 1-866-444-3272, or online at https://www.askebsa.dol.gov/WebIntake.**

**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) COBRA continuation coverage. | □ Yes □ No |
| 2. I am NOT eligible for other group health plan coverage. | □ Yes □ No |
| 3. I am NOT eligible for Medicare. | □ Yes □ No |
| 4. The qualifying event was an involuntary termination or a reduction in hours. | □ Yes □ No |

I make an election to exercise my right to ARP premium assistance. 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) COBRA continuation coverage. | □ Yes □ No |
| 2. I am NOT eligible for other group health plan coverage. | □ Yes □ No |
| 3. I am NOT eligible for Medicare. | □ Yes □ No |
| 4. The qualifying event was an involuntary termination or a reduction in hours. | □ Yes □ No |

I make an election to exercise my right to ARP premium assistance. 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) COBRA continuation coverage. | □ Yes □ No |
| 2. I am NOT eligible for other group health plan coverage. | □ Yes □ No |
| 3. I am NOT eligible for Medicare. | □ Yes □ No |
| 4. The qualifying event was an involuntary termination or a reduction in hours. | □ Yes □ No |

I make an election to exercise my right to the ARP premium assistance. 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_