

**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]*.