

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]
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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 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

<input type="checkbox"/> 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)

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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. I (the dependent) am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. I (the dependent) am NOT eligible for Medicare.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. I (the dependent) am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. I (the dependent) am NOT eligible for Medicare.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. I (the dependent) am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. I (the dependent) am NOT eligible for Medicare.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 → _____