

APPLICANT: To apply for ARRA Premium Reduction, complete this form and return it to: NCAS, PO Box 3065, Fairfax, VA 22038. You should also read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions under ARRA."

APPLICATION FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Employer:
	Telephone number:
Identification 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) COBRA 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. 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 _____

THIS SECTION IS FOR EMPLOYER COMPLETION

This application is: Approved Denied Approved for some/denied for others (explain in #3 below)

Employer: Please send a copy of this approved (or denied) application to NCAS at: P.O. Box 3065, Fairfax, VA 22038 or FAX a copy to (703) 934-6264. If this application is denied, specify the reason below and also send a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

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. Other (please explain)	<input type="checkbox"/>

Signature of Employer _____ Date _____

Type or print name: _____

Telephone number: _____ E-mail address: _____

Note: If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272). A form to request that the DOL review your denial of ARRA premium assistance is now available on the following Website: <http://www.dol.gov/ebsa/COBRA/main.html> (link entitled "ARRA COBRA DOL Form" located under the "Downloads" section).

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

I make an election to exercise my right to the ARRA Premium Reduction. 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. 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 _____

