

Date: June 24, 2009

Code: TECHNICAL LETTER  
HR/Benefits 2009-02  
Supplement #1

To: Human Resources Directors  
Benefits Representatives

From: Bruce Gibson   
Senior Director, Benefits  
Human Resources Administration

Subject: Benefits Update: New Consolidated Omnibus Reconciliation Act (COBRA) Premium Reduction Provisions under the American Reinvestment and Recovery Act (ARRA)

Overview

**Audience:** Human Resources Directors, Benefits Representatives, and/or campus designee(s) responsible for benefits and/or COBRA administration

**Action Item(s):**

**Affected Employee**

**Group(s)/Unit(s):** All employees eligible for COBRA Continuation between September 1, 2008 and December 31, 2009.

Summary

The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009, and provides a 65% COBRA Premium Reduction (COBRA Subsidy) of employer sponsored group health plans for a maximum of nine (9) months to employees who are involuntarily terminated between September 1, 2008 and December 31, 2009, and are eligible for COBRA at the time of the termination. Such (former) employees and their eligible family members are responsible for paying the remaining 35% of the monthly COBRA premium.

This technical letter provides additional information regarding payments of the 65% employer portion of COBRA Premium Assistance to the medical, dental and vision carrier(s).

Campus designees responsible for COBRA administration should read the technical letter in its entirety.

Preliminary information regarding COBRA Premium Assistance was released to campuses on April 13, 2009 (HR/Benefits 2009-02), with an indication that additional information would be forthcoming.

The purpose of this technical letter is to update campuses with the administrative process that Human Resources Administration (HRA) has implemented regarding CSU's payment of the 65% employer portion of COBRA Premium Assistance payable to its medical, dental and vision carriers.

Please note: The Chancellor's Office will assume financial responsibility for the employer portion of COBRA Premium Assistance. As a result, invoices for the employer's 65% portion of COBRA premium assistance will be sent directly to:

**Distribution:**

CSU Presidents  
Executive Vice Chancellor and CFO  
Vice Chancellor, Human Resources  
Vice Presidents, Administration

Associate Vice Presidents/Deans of Faculty  
Budget Officers  
Payroll Managers

CSU Office of the Chancellor  
Attention: Michelle Hamilton, Systemwide Human Resources  
401 Golden Shore  
Long Beach, CA 90802

To facilitate this process, the "Request for Treatment as an Assistance Eligible Individual" form has been updated to reflect the Chancellor's Office as a billing address (see attached). For purposes of campus tracking, the "Campus name and address" section on the form should be personalized.

Campuses that received COBRA Premium Assistance invoices in error can forward them to the Chancellor's Office at the address listed above.

### **Documentation for Audit Purposes**

The IRS requires that campuses maintain records with pertinent information of individuals who received the COBRA Subsidy. Campuses are asked to keep in their records:

- The date of the involuntary termination on which the COBRA Premium Assistance is based. The involuntary termination must occur on or after September 1, 2008, through December 31, 2009.
- Documentation of COBRA eligibility and election of COBRA Premium Assistance.

This information also may be required if the campus receives a request to substantiate the reason(s) for denial of COBRA Premium Assistance.

### **Information Regarding Appeals of COBRA Premium Assistance Denials**

The Department of Labor (DOL) has updated its website with information and forms for individuals who wish to appeal an employer's decision to deny COBRA Premium Assistance requests. Consequently, the Centers for Medicaid and Medicare Services (CMS) will review denial applications from state and federal government employees, such as the CSU.

Individuals may contact the CMS-sponsored premium assistance continuation coverage help desk via e-mail at [continuationcoverage@maximus.com](mailto:continuationcoverage@maximus.com) or call toll-free at (866) 400-6689. Staff members are available from 8 a.m. until 8 p.m. EST. A copy of the "Request for review if you have been denied Premium Assistance" form is attached to this technical letter. In addition, the "Summary of COBRA Premium Assistance Reduction Provisions" has been updated to reflect the CMS website and toll-free telephone number.

### **CMS Processing Instructions**

Currently COBRA Administration is not included in CMS Baseline; therefore, there is no impact to the Base Benefits or Benefits Administration (Ben Admin) Oracle/PeopleSoft applications.

Questions regarding this Technical Letter may be directed to Human Resources Administration at (562) 951-4411. This Technical Letter is also available on the Human Resources Administration Web site at: <http://www.calstate.edu/HRAdm/memos.shtml>.

BG/mh



## Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.\*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

### ◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at [www.irs.gov](http://www.irs.gov).

For general information regarding your plan’s COBRA coverage you can contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact [*enter name of party responsible for ARRA Premium Reduction administration for the Plan, with telephone number and address*].

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 the websites listed below or call (866) 400-6689.

[www.dol.gov.cobra.html](http://www.dol.gov.cobra.html) or <http://www.cms.hhs.gov/COBRAContinuationofCov/>

\* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form and return it to the campus Benefits Office.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

Campus Name and Address:  
California State University

**REQUEST FOR TREATMENT AS AN ASSISTANCE  
ELIGIBLE INDIVIDUAL**

Attn: Health Plan Carrier  
Mail Employer Invoices to:  
CSU, Chancellor's Office  
Systemwide Human Resources  
401 Golden Shore  
Long Beach, CA 90802  
562.951.4411

Campus Address Here

**PERSONAL INFORMATION**

Name and mailing address of employee (list dependents on 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) 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

\*If you checked NO for statement 3, you may still be eligible. See below for more information.

**\*ADDITIONAL ELECTION PERIOD\***

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form which you **MUST** complete and return. If you believe you should have received this additional notice but have not, contact the campus Benefits Office.

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 → \_\_\_\_\_

**FOR EMPLOYER OR PLAN 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.	<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 COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

\*If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ \_\_\_\_\_ Date → \_\_\_\_\_

→ Type or print name → \_\_\_\_\_ Campus \_\_\_\_\_

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. 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 → \_\_\_\_\_

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

**Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.**

**Participant Notification**

**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 plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA 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 or 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:

\_\_\_\_\_  
\_\_\_\_\_



## *Request for Review If You Have Been Denied Premium Assistance*

*Centers for Medicare & Medicaid Services (CMS)*



You **MUST** use this form to request that the Centers for Medicare & Medicaid Services (CMS) review your **denial** of premium assistance to cover the cost of continuation coverage provided under COBRA laws applicable to Federal, State and local government employees and comparable State continuation coverage laws.

**If you fail to send us this completed form, we will NOT be able to review your case.**

### **GENERAL INFORMATION:**

If you lost your health benefits because you or a family member lost the job that provided your health coverage, you may be eligible for “continuation coverage” (sometimes called “COBRA”) which lets you keep your health benefits temporarily after the job ends. If you are eligible for this type of coverage, a new law may help you pay for it. If you meet the requirements described below, you may qualify for “premium assistance,” which will mean your premium will be only 35% of what it would be without the assistance.

**This form is not an application for COBRA coverage. Use this form only if your request for help paying the premium has been denied by your employer, group health plan, or insurer.**

**NOTE:** “COBRA” refers to the federal law that requires large private companies, and state or local government employers, to provide continuation coverage. To make it easier to understand, this form sometimes uses the word “COBRA” to mean **any** kind of continuation coverage. However, this might not be what it is called when it is offered to you. For example, if you worked for the Federal government it will be called “Temporary Continuation of Coverage” or “TCC.”

Fill out the form **completely** and send it to the address listed below, or we cannot review your claim.

To be eligible for this assistance, you must meet ALL of the following requirements:

- ◆ You are eligible for continuation coverage because you or your family member lost a job between **September 1, 2008 and December 31, 2009**;
- ◆ You elect continuation coverage; and
- ◆ You request premium assistance.

If your request for premium assistance is denied by a Federal government employer, a state or local government employer with twenty or more employees, or a private employer under a State continuation coverage program, you can submit this form to CMS for an expedited review of the decision.

Follow the instructions included with this form and mail, fax or deliver (by hand or by courier) your completed request for review to:

MAXIMUS Federal Services, Inc.  
COBRA--Continuation Coverage  
Assistance Appeals Project  
800 Cross Keys Office Park – Suite 820  
1<sup>st</sup> Floor – Suite 822  
Fairport, New York 14450  
Toll-Free Phone No. (866) 400-6689  
TTY: (866) 631-5610  
Toll-Free Fax No. (866) 941-0170  
[ContinuationCoverage@maximus.com](mailto:ContinuationCoverage@maximus.com)  
[www.ContinuationCoverage.net](http://www.ContinuationCoverage.net)

**APPLYING FOR REVIEW:**

When completing your application, answer all of the questions to the best of your knowledge and ability. Because we are required to complete the review in a short timeframe, we are asking for all the information that we think could be relevant to your request. Because a timely review is also to your advantage, please answer as completely as possible. However, we realize that you may not be able to answer every question, so, if you don't know the answer and can't get the information, check the box for "don't know." If you think you know the answer, but are not sure, answer as best you can but check the box marked "unsure." If a particular question does not apply to your case, check the box marked "N/A" ("not applicable.") Feel free to include copies of any documents that may help us in our review. Some examples of these documents are listed in the attached instructions. Since we may need to call you with questions, or to obtain more information, it's important that you provide us with the phone number where you can most likely be reached during the hours of 8 a.m. until 8 p.m. Eastern Time, as well as an alternate phone number, and an email address, if possible, where requested on the form.

If you have any questions about how to complete this form, or about your eligibility for premium assistance, please visit our website at: [www.ContinuationCoverage.net](http://www.ContinuationCoverage.net). You may also contact us via e-mail at: [ContinuationCoverage@maximus.com](mailto:ContinuationCoverage@maximus.com) or via phone (toll-free) at: (866) 400-6689. We cannot, however, accept your application for review over the phone or by e-mail.

**NOTE:** If your continuation coverage is provided through a private sector plan sponsored by an employer with at least 20 employees, you should direct your request for review to the Department of Labor. You can access the DOL website at [www.dol.gov/COBRA](http://www.dol.gov/COBRA) or call toll-free at (866) 444-3272.



# Instructions for the Request for Review If You Have Been Denied Premium Assistance as Provided by the American Recovery and Reinvestment Act of 2009

## Submit to: Centers for Medicare & Medicaid Services (CMS)

**Contact Information** Please complete the fields, if filing by mail or fax, by entering one letter or number per box. Please print clearly.

\*Name Mr.  Mrs.  Ms.

\*Last  \*First  Middle Initial

S M I T H J O H N T

\*Street Address

1 2 3 4 M A P L E L A N E

\*City  \*State  \*Zip Code

A N Y T O W N S T 9 8 7 6 5

**Lines D1-D4** When adding information on your dependents, please remember that a separate application(s) must be completed for any family member who is under a group health plan that is different than yours.

*Please answer Questions 1-11 by placing an X in the appropriate box (  ).*

**Question #1** Answer YES to this question if you were covered by the group health plan. If you were not enrolled but should have been, answer UNSURE and explain the circumstances in the other information section at the end of the application. If a new dependent (or dependents) by birth, adoption, or placement for adoption joined the family of the employee at any time after the date of the qualifying event and a timely request to special enroll the new dependent(s) was made, answer YES to this question.

**Question #2** Answer YES if the employee’s job termination occurred in the period from September 1, 2008 through December 31, 2009. Answer NO if the termination occurred before September 1, 2008 or after December 31, 2009.

**Question #3** Answer YES if the former employer has an ongoing health plan, if your former employer was acquired by another business that provides group health benefits or if the employee's former employer was a "trade or business" under common control. The acquiring business or other employers in the controlled group may have to offer you continuation coverage. If these situations do not describe your health plan, answer NO to this question. If you answer NO, you may have no plan from which to obtain continuation coverage. If so, the premium assistance would not be available to you.

**Question #4** For purposes of the premium assistance, qualifying events such as divorce, legal separation, entitlement to Medicare, a child ceasing to be a dependent child under the terms of the plan, or death of the employee are not terminations of employment.

**Question #5** To be eligible for the premium assistance, the employee's job termination must have been involuntary. Whether a termination of employment is an involuntary termination of employment is determined based on all the relevant facts and circumstances. Examples of situations that may constitute an involuntary termination of employment are listed in Question 5. For help in determining if other situations are involuntary terminations, see pages 7 to 11 of IRS Notice 2009-27 at [www.irs.gov/pub/irs-drop/n-09-27.pdf](http://www.irs.gov/pub/irs-drop/n-09-27.pdf). Check the appropriate box that describes your situation or that of your family member. If none of the examples address the termination, answer YES in Item 5f and describe the circumstances of the termination in the **Other Information** box at the end of the application. Also please note: An employee and his or her dependents may not be eligible for continuation coverage if the employee was terminated from employment for gross misconduct.

**Question #6** If you were employed by a private-sector employer, answer NO. If your benefits were provided by the Federal government, a State or local governmental plan, or a church plan, answer YES.

**Question #7** Answer based upon the number of employees you believe the employer had. We recognize that you may not have the information to confirm this response. Generally, Federal COBRA only applies to group health plans maintained by employers that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year (January 1 to December 31), counting full- and part-time employees. If you answer YES to this question indicating that the employer had 20 or more employees and your continuation coverage would be through a private sector plan, you should direct your request for review to the Department of Labor. You can access the DOL website at [www.dol.gov/COBRA](http://www.dol.gov/COBRA) or call toll-free at (866) 444-3272.

Please note: Although Federal COBRA rules do not apply to these small employers, the premium assistance applies to comparable continuation coverage that is provided pursuant to State law. If you answer NO to this Question indicating that your employer had fewer than 20 employees, your plan may be providing comparable State coverage. Contact your State's Department of Insurance (DOI) as a first step in determining whether State law applies to your coverage and qualifies you for premium assistance under ARRA. You can find a link to your State DOI at: [www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm).

**Question #8** If you were offered continuation coverage in connection with your or your family member's job, select the answer that best addresses the status of your election. The election notice should be provided to qualified beneficiaries and should include information to help you understand continuation coverage, including the name of the plan's administrator. If you received such a notice, answer YES. You must be given an election period (starting on the later of the date the employer sends the notice to you (which, for instance, could be indicated by a postmark date)

or the date you would lose coverage) to choose whether or not to elect continuation coverage. Did you let your plan know that you elected continuation coverage? If so, answer YES. If you requested continuation coverage but were denied, your plan must provide a notice that explains the reason for denying your request. Refer to this notice to answer the question and provide the reason in the **Other Information** section at the end of the application and attach a copy of the notice with your application.

Note that ARRA added a second election period for some individuals who experience an involuntary job termination from September 1, 2008 through February 16, 2009. If these individuals did not elect COBRA continuation coverage on their first opportunity, or elected continuation coverage but dropped it, they have a second opportunity to elect it. This additional election period does not apply to individuals eligible for continuation coverage under comparable State programs unless the State chooses to provide an additional election period.

**Question #9** If you received notice about the premium assistance in either the election form or a General Notice, answer YES. If you were denied the premium assistance, your plan may have provided you written notification of the reason for the denial, possibly on the form you used to request the premium assistance. If so, refer to that document to provide the reason in the **Other Information** section at the end of the application and attach a copy of the document with your application. If you have received no response to your request, you should answer "Unsure."

**Question #10** Answer YES if you are *eligible for coverage* under another group health plan or Medicare benefits. If you answer YES to this Question, you are not eligible for the premium assistance on the first date of eligibility for the other coverage. Note: if you are eligible for the premium assistance, you are required to notify the plan when you become eligible for Medicare or other group health coverage. Failure to do so may subject you to a penalty of 110 percent of the amount of any premium assistance.

**Question #11** If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return), all or part of the premium assistance may be recaptured by an increase in your income tax liability for the year. If you have continuation coverage, but wish to avoid this recapture, you may delay electing or permanently waive the premium assistance and pay the entire premium. If you exercised a permanent waiver, it cannot be withdrawn even if your income falls below these levels. For more information on the income tax recapture, consult your tax preparer or contact the IRS at [www.irs.gov](http://www.irs.gov). If you waived the right to collect the premium assistance, answer YES and attach copies of any relevant documentation that you have.

**Information on the employer, plan sponsor, insurance company, and/or benefits administrator** Refer to the notice you received to find the information to use for this application. Attach a copy of the notice to your application.

**Other Information** Please provide what you were told about the reason(s) you were denied continuation coverage and/or the premium assistance as well as any other information you believe is important for the CMS to know in order to evaluate your application.

**Attachments** Since our review cannot begin until we receive a complete application, please attach copies of documentation that you believe would assist us in making a determination. Such documentation could include copies of one or more of the following items, if applicable: your election notice, your Request for Treatment as an Assistance Eligible Individual or other form used to request the premium assistance, your insurance card, payroll stubs showing deductions for health benefits, any documents detailing the date and circumstances of the termination of the employee's employment, or any documentation you were provided regarding the denial of the premium assistance.



*Request for Review If You Have Been Denied Premium Assistance*



*Centers for Medicare & Medicaid Services (CMS)*

OMB Control Number 0938-1062 Exp. Date 11/30/2009

**Applicant's Information \***

**\* Denotes required information**

\*Name Mr.  Mrs.  Ms.

\*Last  \*First  Middle Initial

\*Street Address

\*City  \*State  \*Zip Code

\*Best phone number to reach you between 8 a.m. and 8 p.m., EST  -  -   
Alternate phone number(s)  -  -

\*E-mail address

\*Date employee's employment was terminated. (month/day/year)  /  /   
\*Date employer stopped paying for the applicant's costs of health insurance under group health plan. (month/day/year)  /  /

Applicant's relationship to employee: Self  Spouse  Child  Other (explain)

If applicant is not the employee, provide the name of the employee

Names of dependents for whom you are also requesting a determination regarding a denial of premium assistance, if any. **Reminder:** if any family member is covered under a different plan than yours, complete a separate application for him or her.

Name	Relationship	Age
D1)		
D2)		
D3)		
D4)		

Attach an additional page if you need to add more dependents to the list.

**Note:** The applicant (person requesting review of a denial of premium assistance) may either be the employee or a member of the employee's family who has received continuation coverage through the employer's group health plan. In some instances, a former employee's dependents may still be able to continue such health insurance--and receive assistance with premiums paid for that health insurance--even though the employee is not continuing such coverage.

<i>Eligibility: Please see instructions for assistance in answering the questions below.</i>	<i>Yes</i>	<i>No</i>	<i>Unsure or N/A</i>
*1. Were you covered by the employer's group health plan on the day before the employee was terminated? If this is being answered for a new dependent (or dependents) born to, adopted by, or placed for adoption with the employee, refer to the instructions to answer the question for the new dependent.			
*2. Was your or your family member's employment terminated in the period from September 1, 2008 through December 31, 2009?			
*3. Is there an ongoing health plan? Are employees who currently work where you or your family member used to work still covered by health insurance that the employer--or another company--provides? (Or is there another employer (such as a parent company) which may be responsible for providing continuation coverage to you?)			
*4. Are you eligible for continuation coverage because of the loss of your job or your family member's job? If so, answer YES. If you are eligible for continuation coverage because of divorce, legal separation, entitlement to Medicare, loss of dependent status, or death of the covered employee, answer NO.			

**PLEASE NOTE:** If you answered NO to any of the Questions above (1-4) you may not be eligible for continuation coverage premium assistance. If you have questions about the requirements for premium assistance, or otherwise need assistance completing this application, please contact MAXIMUS Federal Services toll-free at (866) 400-6689.

	<i>Yes</i>	<i>No</i>	<i>Unsure or N/A</i>
*5. Was the employee's job termination involuntary?			
a. Was it a permanent layoff?			
b. Was it a temporary layoff with possible recall?			
c. Was it a buyout or severance package in anticipation of a layoff?			
d. Did the employee resign as a result of a major change in the geographic location of employment?			
e. Did the employee's employment end while the employee was absent due to illness or disability?			
f. Other reason the employment was terminated? – Check "Yes" and please describe in the <b>Other Information</b> box at the end of the application.			

For more information that may help you to answer the above questions, see pages 7 - 11 of the IRS Notice 2009-27 at [www.irs.gov/pub/irs-drop/n-09-27.pdf](http://www.irs.gov/pub/irs-drop/n-09-27.pdf).

*6. Did you or your family member work for the Federal government, a State or local government, or a church?			
*7. Did your former employer or your family member's former employer have 20 or more employees in the calendar year prior to the year in which you or your family member was terminated?			

*8. Regarding continuation coverage	<i>Yes</i>	<i>No</i>	<i>Unsure or N/A</i>
a. Did you get a notice informing you of your right to elect continuation coverage?			
b. Did you send in a form requesting, or electing, coverage?			
c. Were you denied continuation coverage? If yes, explain the reason in the <b>Other Information</b> box at the end of the application. Attach copies of all relevant documents.			
d. If you received continuation coverage, what date did it start? (month/day/year) <input type="text"/> / <input type="text"/> / <input type="text"/>			
e. If you received continuation coverage, what date did it end? (month/day/year) <input type="text"/> / <input type="text"/> / <input type="text"/>			
Explain the reason your continuation coverage ended in the <b>Other Information</b> box at the end of the application. Attach copies of all relevant documents.			
*9. Regarding the COBRA premium assistance	<i>Yes</i>	<i>No</i>	<i>Unsure or N/A</i>
a. Did you get a notice informing you that you may be eligible for premium assistance?			
b. Did you apply for the premium assistance? (For instance call, write, or e-mail the employer or its group health plan or send in the form called Request for Treatment as an Assistant Eligible Individual.)			
c. Were you denied the premium assistance? If yes, explain the reason in the <b>Other Information</b> box at the end of the application below. Attach copies of all relevant documents.			
*10. At any time after you or your family member lost his or her job were you (or any dependents) eligible to receive health insurance coverage under any other group health plan (such as a plan sponsored by a later employer or a spouse's employer) or Medicare? If yes, please note the date you (or any dependents) became eligible for the other coverage. (month/day/year) <input type="text"/> / <input type="text"/> / <input type="text"/>			
*11. Did you sign any form saying you don't want the premium assistance? (In other words, did you exercise any waivers of your right to the premium assistance?)			





Plan Sponsor's e-mail address

Plan Sponsor's website address

*Parent Company or Purchaser: If another company such as a parent company or a company that recently bought the employer, may be responsible for providing continuation coverage, please provide as much information as possible about that company and its connection to the employer. (Attach an additional sheet, if needed.)*

\*Parent Company or Purchaser's Name

Best person at parent co./purchaser to contact

Name Mr.  Mrs.  Ms.

Last

First

Middle Initial

\*Street Address

\*City

\*State

\*Zip Code

\*Phone Number

Fax Number

Parent Co./Purchaser's e-mail Address

Parent Co./Purchaser's website address

*Insurance, HMO or Benefits Administrator Information: If applicable, please enter the following information as completely as possible about the insurance company, health maintenance organization (HMO) or benefits administrator that administers benefits for your employer's group health plan and attach any supporting documentation you have.*

\*Name of Plan (ex. ABC Insurance Co PPO, Company Group Plan)

Name of Insurer or Benefits Administrator

Best person to contact

Name Mr.  Mrs.  Ms.

Last

First

Middle Initial

\*Street Address



Under the penalty of perjury, I declare that I have examined this application, including any accompanying attachments, and to the best of my knowledge and belief, it is true, correct and complete. I hereby authorize the release of the information contained in and attached to this application, as well as any additional oral or written information that may be collected in connection with this review process, to any other parties to this review, including the health plan and my or my family member's former employer. I further authorize the individuals involved in processing this review to discuss with other individuals such information as they may deem necessary in resolving this review.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Type or print name: \_\_\_\_\_

**Privacy Act Notice**

The Privacy Act of 1974 requires that when we ask you for information we tell you our legal right to ask for the information, why we are asking you for it, and how it will be used. We must also tell you what could happen if we do not receive it and whether your response is voluntary, required to obtain a benefit, or mandatory. Our legal right to ask for the information is section 3001(a)(5) of the American Recovery and Reinvestment Act of 2009 (ARRA). We are asking for this information to comply with the provisions of ARRA and to enable the Secretary of Health and Human Services to make a determination on your application for the Secretary's expedited review of the denial of your request for treatment as an assistance eligible individual. If you do not provide the requested information, you will not be eligible for such review. We do not sell the information that we collect. The personal information that you give us will be used only in connection with the Secretary's expedited review of the denial of your request for treatment as an assistance eligible individual.

We use contractors to perform various website and database functions. When we do, we make sure that the agreement language with the contractor ensures the security, confidentiality and integrity of any personal information to which the contractor may have access in the course of contract performance.

While online filing is secure, electronic mail is not secure. Therefore, we suggest that you don't send personal information to us by email. We will only send general information to you by email.

We may disclose the information you give us if authorized or required by Federal law, such as the Privacy Act. We may also disclose this information to the other parties to this review, including your health plan and, in many cases, to the employee's former employer, as well as to the courts as a part of the record on any appeal. You may have access to any of the information we collect about you. Also, if you provide false or fraudulent information, you may be subject to criminal prosecution. See section 1027, Title 18, U.S. Code (False statements and concealment of facts in relation to documents required by ERISA) and section 1001, Title 18, U.S. Code (Fraud and False Statements - Statements or entries generally). Other penalties may also apply.

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1062. The time required to complete this information collection is estimated to average one (1) hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. The obligation to respond to this collection is required to obtain or retain benefit (*see* section 3001(a)(5) of the American Recovery and Reinvestment Act, P.L. 111-5). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.