

**Model ARP General Notice and COBRA Continuation Coverage Election Notice**  
**(For use by group health plans for qualified beneficiaries who have qualifying events occurring from April 1, 2021 through September 30, 2021)**

**Instructions**

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage election notice that the Plan may use to provide the election notice. To use this model election notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers appropriate use of the model election notice to be good faith compliance with the election notice content requirements of COBRA and the American Rescue Plan Act of 2021 (ARP). You don't have to use the model notice, but it may help you comply with the applicable notice requirements. When distributing the model notice, the Plan Administrator should also include the attachment "*Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021*," which contains information on the ARP, and forms to elect or discontinue the premium assistance, in order to satisfy the notice requirements of the ARP.

**NOTE:** Plans do *not* need to include this instruction page with the model election notice.

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

Collection of this information is authorized by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and section 9501 of the American Rescue Plan Act (Pub. L. 117-2). The obligation for employers to respond to this collection is mandatory to provide the required notices to allow individuals to obtain benefits allowed by the law. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Regulations and Interpretations, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0167.

The public reporting burden for this collection of information is shown in the following table.

<b>Notice Type</b>	<b>Estimated Average Time</b>
General Notice	Minimal additional burden as already covered under OMB Control Number 1210-0123.
Notice in Connection with Extended Election Periods	1 minute per response
Alternative Notice	2 minutes per response
Notice of Expiration of Premium Assistance	1 minute per response

**Model ARP General Notice and COBRA Continuation Coverage Election Notice**  
**(For use by group health plans for qualified beneficiaries who have qualifying events occurring from April 1, 2021 through September 30, 2021)**

**IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives**

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

**This notice has important information about your rights related to continued health care coverage in the [enter name of group health plan] (the Plan), as well as other health coverage options that may be available to you, including coverage through Medicaid or the Health Insurance Marketplace<sup>®1</sup>. To sign up for Marketplace coverage, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325). People in most states use [www.HealthCare.gov](http://www.HealthCare.gov) to apply for and enroll in health coverage; if your state has its own Marketplace platform, you can find contact information here: [www.HealthCare.gov/marketplace-in-your-state/](http://www.HealthCare.gov/marketplace-in-your-state/).**

Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the Election Form provided later in this notice.

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for COBRA continuation coverage and, where the employer elects to offer the option, an opportunity to switch to a different health plan option offered by the employer. The premium assistance is available to certain individuals who are eligible for COBRA continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for the premium assistance, you need not pay any of the COBRA premium otherwise due to the plan. This premium assistance is available from April 1, 2021 through September 30, 2021. If you continue your COBRA continuation coverage beyond that date, you will have to pay the full amount due. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace<sup>®</sup> (see section on “the Health Insurance Marketplace<sup>®</sup>” below).

To determine whether you are eligible for COBRA premium assistance under the ARP, carefully review this notice and the attached document titled “Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021”. **If you believe you are an eligible individual and want to elect COBRA continuation coverage with temporary premium assistance, complete the “Request for Treatment as an Assistance Eligible Individual” and return it to the health plan with your completed Election Form.**

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<sup>1</sup> Health Insurance Marketplace<sup>®</sup> is a registered service mark of the U.S. Department of Health & Human Services. OMB Control Number 1210-0167. Expiration Date: October 31, 2021

### Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on [enter date] due to [check appropriate box]:

- End of employment (voluntary)
- End of employment (involuntary)
- Death of employee
- Entitlement to Medicare
- Reduction in hours of employment
- Divorce or legal separation
- Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event," such as those listed above, that would result in a loss of coverage under an employer's plan.

### What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

### Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can independently elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage (A parent or legal guardian can *elect on behalf of a dependent.*)
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

### Are there other coverage options besides COBRA continuation coverage?

Yes. There may be other coverage options for you and your family through a Marketplace, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Additionally, you may apply for and, if eligible, enroll in Medicaid at any time. If you are not eligible for premium assistance under the ARP, some of these options may cost less than COBRA continuation coverage. If you are eligible for other group health coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a qualified small employer health reimbursement arrangement (QSEHRA), or a health flexible spending arrangement (FSA)), or if you are eligible for Medicare, you are not eligible for ARP premium assistance. However, if you have individual health insurance coverage, like a plan through a Marketplace, or if you have Medicaid, you may be eligible for ARP premium assistance if you elect COBRA continuation coverage. You will not be eligible

for a premium tax credit, or advance payments of the premium tax credit, for your Marketplace coverage for months you are enrolled in COBRA continuation coverage and you may not be eligible for months during which you remain an employee but are eligible for COBRA continuation coverage with premium assistance because of a reduction of hours. If you're eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. Also, keep in mind that if you elect COBRA continuation coverage with premium assistance, then you may qualify for a special enrollment period to enroll in Marketplace coverage when your premium assistance ends. You may use the special enrollment period to enroll in Marketplace coverage with a tax credit if you end your COBRA continuation coverage when your premium assistance ends and you are otherwise eligible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

**If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?**

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date]*. If your COBRA qualifying event was the employee's reduction in hours or involuntary termination of employment, you may be eligible for ARP premium assistance from *[enter April 1 or if qualifying event is after this date the date of qualifying event]* through September 30, 2021.

*[Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options]].*

*[If the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred, insert: "In addition, under the ARP, you may have the right to change to additional coverage options that you were not previously enrolled in. To change the coverage option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment or before your reduction in hours, complete the "Form for Switching COBRA Continuation Coverage Benefit Options" and return it to us. Available coverage options are: [insert list of available coverage options]." To be eligible for premium assistance, the different coverage must cost the same or less than the coverage you had at the time of the qualifying event; be offered to similarly situated active employees; and cannot be limited to only excepted benefits, a QSEHRA or a health FSA.]*

COBRA continuation coverage may end before the date noted above in certain circumstances, including for failure to pay premiums, for fraud, or if you become covered under another group health plan or entitled to Medicare.

## **Can I extend the length of COBRA continuation coverage?**

If you elect COBRA continuation coverage, you may be able to extend the length of COBRA continuation coverage if a qualified beneficiary is disabled or if a second qualifying event occurs. You must notify *[enter name of party responsible for COBRA administration]* of a disability or a second qualifying event within a certain time period to extend the period of COBRA continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage, visit <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf>.

## **How much does COBRA continuation coverage cost?**

COBRA continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]*

ARP reduces the COBRA premium to zero in some cases. If you qualify as an "Assistance Eligible Individual" under the ARP, the monthly premium cost will be zero through September 30, 2021.

If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment, if necessary, will be provided to you after the Election Form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

**You may qualify for a special enrollment period to enroll in Marketplace coverage when your COBRA continuation coverage and/or your premium assistance ends. You may be able to get coverage through Medicaid or the Health Insurance Marketplace®.** You can learn more about the Marketplace below.

## **What is the Health Insurance Marketplace®?**

The Health Insurance Marketplace® offers "one-stop shopping" to find and compare private individual health insurance options. In the Marketplace, you could be eligible for a subsidy that lowers your monthly premiums and for cost-sharing reductions (that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your subsidized premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Under the ARP, individuals and families may be eligible for a temporary increase in their premium tax credit, and advance payments of the premium tax credit, for this year, with no one who is eligible paying more than 8.5% of their household income towards the cost of the benchmark plan or a less expensive plan for plan years 2021 and 2022. Through a Marketplace, you can also learn if you may qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). People in most states use HealthCare.gov to apply

for and enroll in Marketplace coverage; if your state has its own Marketplace platform you can find contact information for your State Marketplace here: <https://www.healthcare.gov/marketplace-in-your-state/>.

Being offered COBRA continuation coverage won't limit your eligibility for Medicaid. It also won't limit your eligibility for Marketplace coverage or for a subsidy through a Marketplace, if you are a former employee of the employer offering the coverage. But you won't be eligible for a subsidy or a tax credit during any month that you're enrolled in COBRA continuation coverage. Therefore, if you want to use a special enrollment period to enroll in Marketplace coverage with a subsidy or a tax credit, you must end your COBRA continuation coverage before your Marketplace coverage starts.

If you are currently employed by the employer offering the COBRA continuation coverage with premium assistance, you may enroll in Marketplace coverage but you may be ineligible for a subsidy or a premium tax credit for the Marketplace coverage for the period you are offered the COBRA continuation coverage with premium assistance.

### **When can I enroll in Marketplace coverage?**

Marketplace-eligible consumers can enroll in Marketplace coverage if they qualify for a special enrollment period. For example, Marketplace-eligible consumers always have 60 days from the time they lose your job-based coverage to enroll in the Marketplace, or they can apply up to 60 days beforehand if they know they'll lose coverage ahead of time. **After 60 days, the special enrollment period will end and Marketplace-eligible consumers may not be able to enroll unless they qualify for another special enrollment period, so they should take action right away if they want to enroll in Marketplace coverage.** In addition, during what is called an "open enrollment" period, Marketplace-eligible consumers can enroll from November 1 – December 15 in Marketplace coverage that starts on January 1. Finally, they may apply for and, if eligible, enroll in Medicaid coverage at any time.

Note that due to COVID-19, for Marketplaces that use HealthCare.gov, all Marketplace-eligible consumers who are submitting a new application or updating an existing application can access a special enrollment period available through the HealthCare.gov platform from February 15 through August 15 of 2021. For more information, please see: [www.HealthCare.gov/sep-list/](http://www.HealthCare.gov/sep-list/). Marketplace-eligible consumers in states with Marketplaces that do not use the HealthCare.gov platform should consult their Marketplace to find out whether they have a special enrollment period available to them. If your state has its own Marketplace platform you can find contact information for your State Marketplace here: [www.HealthCare.gov/marketplace-in-your-state/](http://www.HealthCare.gov/marketplace-in-your-state/).

Additionally, under the ARP, individuals and families may be eligible for a temporary increase in their premium tax credit and advance payment of the premium tax credit for 2021 and 2022, with no one who is eligible paying more than 8.5% of their household income towards the cost of the benchmark plan or a less expensive plan.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-](http://www.HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-)

[period/](#). If your state has its own Marketplace platform, you can find contact information for your State Marketplace here: <https://www.HealthCare.gov/marketplace-in-your-state/>. Note, you may apply for and, if eligible, enroll in Medicaid coverage at any time.

**If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during the annual Marketplace open enrollment period or during a special enrollment period. If you elect COBRA continuation coverage with premium assistance, then you may qualify for a special enrollment period to enroll in Marketplace coverage when your premium assistance ends. You may use the special enrollment period to enroll in Marketplace coverage with a tax credit if you end your COBRA continuation coverage when your premium assistance ends and you are otherwise eligible. But be careful: if you terminate your COBRA continuation coverage early without another event that qualifies you for special enrollment, you may have to wait to enroll in Marketplace coverage until the next available open enrollment period, and could end up without any health coverage in the interim.

Alternatively, once you've exhausted your COBRA continuation coverage and the coverage expires, you may be eligible for a special enrollment period to enroll in Marketplace coverage, if you are Marketplace-eligible, even if Marketplace open enrollment has ended and no other qualifying events apply. For more information on COBRA continuation coverage and the Marketplace, see [www.HealthCare.gov/unemployed/cobra-coverage/](http://www.HealthCare.gov/unemployed/cobra-coverage/).

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your COBRA election period ends.

**Can I enroll in another group health plan?**

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period<sup>2</sup> to sign up, beginning on the earlier of:

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<sup>2</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>. These rules are different for people with End Stage Renal Disease (ESRD).



- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B lifetime late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued based on Medicare eligibility, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

### **What factors should I consider when choosing coverage options?**

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA continuation coverage (or up to 150% of total plan premiums after 18 months if you choose to extend the COBRA continuation coverage period beyond 18 months due to the disability of a qualified beneficiary) if you are not eligible for premium assistance under the ARP. If you are eligible for premium assistance under the ARP, your plan can charge this amount if you continue your COBRA continuation coverage beyond September 30, 2021. Other options, like coverage on a spouse's plan, Medicaid or coverage through a Marketplace plan, may be less expensive at that point.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network and whether you will have access to that network through any other option as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA continuation coverage premium payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments. You may also want to consider whether you have met your deductible or maximum out-of-pocket limit under your COBRA continuation coverage.

### **For more information**

This notice doesn't fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in your summary plan description or from your Plan Administrator.

If you have questions about the information in this notice or your rights to coverage, or if you want a copy of your summary plan description, contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at <https://www.dol.gov/agencies/ebsa>, contact them electronically at [askebsa.dol.gov](mailto:askebsa.dol.gov), or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace®, and to locate an assister in your area who you can talk to about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

## COBRA Continuation Coverage Election Form

**Instructions:** To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage and the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance under the ARP.

Send completed Election Form to: *[Enter Name and Address]*

This Election Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*.

If you don't submit a completed Election Form by the due date shown above, you may lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.

**Read the important information about your rights included in the pages after the Election Form.**

I (We) elect COBRA continuation coverage in the *[enter name of plan]* (the Plan) listed below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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a. \_\_\_\_\_

*[Add if appropriate: Coverage option elected: \_\_\_\_\_]*

b. \_\_\_\_\_

*[Add if appropriate: Coverage option elected: \_\_\_\_\_]*

c. \_\_\_\_\_

*[Add if appropriate: Coverage option elected: \_\_\_\_\_]*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

[Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.]

**Form for Switching COBRA Continuation Coverage Benefit Options**

**Instructions:** To change the benefit option(s) for your COBRA continuation coverage to something different than what you or the participating employee had on the last day of coverage, complete this form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send completed form to: [Enter Name and Address]

This form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than [enter date].

**\*THIS IS NOT YOUR ELECTION NOTICE\***  
**YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR COBRA CONTINUATION COVERAGE.**

I (We) would like to change the COBRA continuation coverage option(s) in the [enter name of plan] (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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a. \_\_\_\_\_

Old Coverage Option: \_\_\_\_\_

New Coverage Option: \_\_\_\_\_

b. \_\_\_\_\_

Old Coverage Option: \_\_\_\_\_

New Coverage Option: \_\_\_\_\_

c. \_\_\_\_\_

Old Coverage Option: \_\_\_\_\_

New Coverage Option: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

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

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

## Important Information About Payment

The following payment information is relevant for individuals who are not eligible for the premium assistance under the ARP:

### *First payment for COBRA continuation coverage*

You must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all COBRA continuation coverage rights under the Plan.<sup>3</sup> You're responsible for making sure that the amount of your first payment is correct. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

### *Periodic payments for continuation coverage*

After you make your first payment for COBRA continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due [*enter due day for each monthly payment*] for that coverage period. [*If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for COBRA continuation coverage for the following coverage periods, due on the following dates:.*] If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one: will or will not*] send periodic notices of payments due for these coverage periods.

### *Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period [*or enter longer period permitted by Plan*] to make each periodic payment. You'll get COBRA continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you*

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<sup>3</sup> Due to the COVID-19 National Emergency, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service issued guidance extending timeframes for certain actions related to health coverage under group health plans sponsored by private employers. This guidance may give you more time to make COBRA premium payments, as premium assistance is not available for periods of COBRA continuation coverage beginning before April 1, 2021. For additional information about this guidance visit:

<https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief>.

submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to:

*[enter appropriate payment address]*

*[Attach "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021" in order to satisfy ARP requirements]*



## Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021

President Biden signed H.R. 1319, the American Rescue Plan Act of 2021 (ARP), on March 11, 2021. This law subsidizes the full COBRA premium for “Assistance Eligible Individuals” for periods of coverage from April 1, 2021 through September 30, 2021.

To be eligible for the premium assistance, you:

- **MUST** have a COBRA qualifying event that is a reduction in hours or an involuntary termination of a covered employee’s employment;
- **MUST** elect COBRA continuation coverage;
- **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 new employer or a spouse’s employer. \*

### ◆ IMPORTANT ◆

- ◇ If you do not elect to receive the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance.
- ◇ If you elect COBRA continuation coverage with premium assistance, and then become eligible for other group health plan coverage (not including coverage that is only excepted benefits (such as dental or vision coverage), a Qualified Small Employer Health Reimbursement Arrangement, or a health flexible spending arrangement), or if you become eligible for Medicare, you **MUST** notify the plan in writing. If you fail to provide this notice, you may be subject to a penalty of \$250 (or if the failure is fraudulent, the greater of \$250 or 110% of the premium assistance provided after termination of eligibility). You won’t be subject to the penalty if your failure to notify the plan is due to reasonable cause and not due to willful neglect.
- ◇ Employers that don’t satisfy COBRA continuation coverage requirements may be investigated by the Department of Labor and may be subject to an excise tax under the Internal Revenue Code.
- ◇ If you elect COBRA continuation coverage and are eligible for the premium assistance, you cannot claim the Health Coverage Tax Credit. You also cannot qualify for a premium tax credit to help pay for coverage through a Health Insurance Marketplace<sup>®1</sup>, such as on HealthCare.gov, for any months that you are enrolled in COBRA continuation coverage with or without the premium assistance.

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

For specific information on your plan’s administration of the ARP premium assistance or to notify the plan of your ineligibility to receive premium assistance, contact [enter name of party responsible for ARP Premium Assistance administration for the Plan, with telephone number and address].

For more information regarding ARP premium assistance and eligibility questions, visit:

<https://www.dol.gov/cobra-subsidy> or contact the Department of Labor at [askebsa.dol.gov](http://askebsa.dol.gov) or 1-866-444-EBSA (3272)

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\* This restriction does not include coverage under a plan that provides only excepted benefits, a qualified small employer health reimbursement arrangement, or coverage under a health flexible spending arrangement.

<sup>1</sup> Health Insurance Marketplace<sup>®</sup> is a registered service mark of the U.S. Department of Health & Human Services.

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.	<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 premium assistance).	<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 premium assistance).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/>
2. Individual did not experience a reduction in hours.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

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.	<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
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<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
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<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
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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    →                      \_\_\_\_\_

This form is designed for plans to distribute to COBRA qualified beneficiaries who are not paying premiums pursuant to ARP 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 premium assistance under the ARP.**

Plan Name

**Participant Notification**

Plan Mailing Address

**PERSONAL INFORMATION**

Name and mailing address

Telephone number

E-mail address (optional)

**PREMIUM ASSISTANCE 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 when you become eligible for other group health plan coverage or Medicare AND continue to receive COBRA premium assistance you may be subject to a penalty of \$250 dollars (or if the failure is fraudulent, the greater of \$250 or 110% of the amount of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the plan is due to reasonable cause and not due to willful neglect.**

**Eligibility for other coverage 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:

\_\_\_\_\_

\_\_\_\_\_