

## Extended Coverage/COBRA Continuation Coverage Election Notice

(Information to be provided by Agency Benefits Administrator is noted in red)

### Date of Notice

**Name and Address:** To the former employee and/or other qualified beneficiaries—those covered on the day before the qualifying event who lost coverage due to that event. If there is more than one qualified beneficiary and they all live at the same address, names of all qualified beneficiaries are not required. Instead, you may use their status.

Examples: Just the employee--Mary Smith  
Employee and spouse--Mary Smith and spouse  
Family coverage--Mary Smith, spouse and dependent children or Mary Smith and dependent children;  
Just Mary's daughter—Jane Smith.

Unless you know that all qualified beneficiaries do not live at the same address, one notice, properly addressed, can be mailed to all.)

**This notice contains important information about your right to continue your health care coverage in the Commonwealth of Virginia Health Benefits Program (the Plan).** Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. Because you experienced a loss of coverage that occurred during the period covered by ARRA (September 1, 2008 through December 31, 2009), you may be eligible for a temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, refer to the *“Summary of the COBRA Premium Reduction Provisions under ARRA”* with details regarding eligibility, restrictions, and obligations and the *“Application for Treatment as an Assistance Eligible Individual.”* **If you believe you meet the criteria for the premium reduction, complete the *“Application for Treatment as an Assistance Eligible Individual”* and return it with your completed *Election Form*.**

To elect COBRA continuation coverage, use the instructions on the following pages to complete the enclosed *Election Form* and submit it as indicated.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on **(enter date that coverage ends due to the qualifying event)** due to: **(check box/es indicating the qualifying event/s)**

- End of employment
  - Involuntary
  - Voluntary
- Divorce from employee or retiree
- Death of employee or retiree
- Reduction in hours of employment resulting in loss of coverage
- Loss of dependent child status

Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to **(enter 18 or 36 based on the event)** months: **(check appropriate box/es)**

- 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
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on **(enter first day of COBRA continuation period)** and can last until **(enter last day of the 18<sup>th</sup> or 36<sup>th</sup> month)**.

The Commonwealth of Virginia Health Benefits Program allows COBRA qualified beneficiaries to make a plan change at the start of COBRA coverage; however, if you are an Assistance Eligible Individual, you may not receive premium assistance for a plan that costs more than the plan that you had at the time of the qualifying event that resulted in your loss of coverage. Your *Enrollment Form* includes a list of available plans.

The cost for COBRA continuation coverage is provided below. (Contact your Benefits Administrator if you need premium rates to continue a Medicare-coordinating plan.) You do not have to send any payment with the *Election Form*. Important additional information about payment for COBRA continuation coverage is included in the pages following the *Election Form*.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact **(enter the name, address and telephone number of the agency Benefits Administrator issuing this notice)**. If you have questions after you elect COBRA continuation coverage, contact the Office of Health Benefits COBRA Administrator (see “For More Information”).

### Commonwealth of Virginia COBRA Premium Rates (18 or 36-month events) July 1, 2009—June 30, 2010

#### Monthly premiums without assistance\*

Plan	Single	Two-Person	Family
COVA Care/Connect (CC) Basic	\$495	\$916	\$1,339
CC + Out-of-Network	\$507	\$932	\$1,361
CC + Expanded Dental	\$510	\$946	\$1,383
CC + Vision, Hearing, Expanded Dental	\$520	\$965	\$1,409
CC + Out-of-Network, Expanded Dental	\$521	\$961	\$1,404
CC + Out-of-Network, Vision, Hearing, Expanded Dental	\$531	\$979	\$1,428
COVA HDHP	\$397	\$735	\$1,075
Kaiser	\$488	\$900	\$1,313

#### Monthly premiums with assistance\*

Plan	Single	Two-Person	Family
COVA Care/Connect (CC) Basic	\$173	\$321	\$469
CC + Out-of-Network	\$177	\$326	\$476
CC + Expanded Dental	\$179	\$331	\$484
CC + Vision, Hearing, Expanded Dental	\$182	\$338	\$493
CC + Out-of-Network, Expanded Dental	\$182	\$336	\$491
CC + Out-of-Network, Vision, Hearing, Expanded Dental	\$186	\$343	\$500
COVA HDHP	\$139	\$257	\$376
Kaiser	\$171	\$315	\$460

\*Premiums will be adjusted to reflect family groups that have both Assistance Eligible and Non-Assistance Eligible Individuals. Retirees enrolled in the State Retiree Health Benefits Program who are also eligible for premium assistance due to retirement in lieu of involuntary termination will have the amount of their retiree premium reduced.

# COBRA Continuation Coverage Election Form

**Instructions:** To elect COBRA continuation coverage, complete this *Election Form* and return it to the address listed below. Under federal law, you have the later of either 60 days after coverage is lost due to the qualifying event or 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed *Election Form* to: **(Name, Address and Telephone Number of The Benefits Administrator issuing this Notice)**

This *Election Form* must be completed, returned by mail, and postmarked no later than **(provide the date at the end of the 60-day election window)**.

If you do not submit a completed *Election Form* by the due date shown above, you will 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 furnish 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 the first month after you furnish 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 Commonwealth of Virginia Health Benefits Program (the Plan) as indicated below. Include employee's name if employee is enrolling.

Name	Date of Birth	Relationship to Employee	Social Security No.	Elect MRA*	Decline COBRA

\*If you wish to continue your existing Medical Reimbursement Account, check here (see following *Important Information* section)

Signature of Enrollee or Representative

Date:

\_\_\_\_\_

\_\_\_\_\_

Print Name:

Relationship to individual(s) listed above:

\_\_\_\_\_

\_\_\_\_\_

Print Address:

Telephone number:

\_\_\_\_\_

\_\_\_\_\_

If the employee became entitled to Medicare (Part A or B) within the 18 months prior to termination of employment or reduction of hours, please indicate eligibility date here \_\_\_\_\_.



## **Important Information About Your COBRA Continuation Coverage Rights**

### **What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, special enrollment rights, and consistent changes due to qualifying mid-year events. Your member handbook contains additional information regarding qualifying mid-year events.

### **Medical Reimbursement Accounts**

Employees who are enrolled in a Medical Reimbursement Account may also choose to extend current participation in that program if, on the event date, the maximum benefit available for the remainder of the plan year is more than the maximum amount that the plan could require as payment for the remainder of the year. Continued contributions may be made to Fringe Benefits Management Company (address available through your Benefits Administrator) up to the last month of the plan year for which you are enrolled at the time of the qualifying event.

### **How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s (or retiree’s) death, divorce, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee can last until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

It is the obligation of the qualified beneficiary to notify the Office of Health Benefits COBRA Administrator in writing within 30 days of the start of coverage under another group health plan or Medicare after the election of COBRA/Extended Coverage. Upon report of other group health plan coverage or entitlement to Medicare, COBRA/Extended Coverage will be terminated at the end of the month in which that coverage begins, or if it begins on the first day of the month, the end of the previous month. Failure to report these events within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had the events been reported timely. Premiums paid during that period will be refunded, and any paid claims will be retracted.

***(If the maximum period shown on page one of this notice is less than 36 months, add the following section, "How can you extend the length of COBRA continuation coverage?" If the maximum period on page one is 36 months, leave this section out.)***

### **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of Health Benefits COBRA Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

#### *o Disability*

An 11-month extension of coverage may be available if any qualified beneficiary is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notification of the disability determination must be given to the Office of Health Benefits COBRA Administrator within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this notice or the General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary (e.g., employee, spouse or dependent child);
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative).

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, he or she must notify the Plan of that fact within 30 days after that determination by providing documentation from the Social Security Administration. Failure to report the end of the disability status within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had it been reported timely (the first of the month that is more than 30 days after the determination). Premiums paid during that period will be refunded, and any claims paid will be retracted.

#### *o Second Qualifying Event*

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation

coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. Notification should include the following information:

- The type of second qualifying event (e.g., death, divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support, death certificate);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of additional Extended Coverage eligibility.

### **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the *Election Form* and an *Enrollment Form* and furnish both to your Benefits Administrator. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is included with this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. This could include employees who retire in lieu of involuntary termination of employment. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA coverage after premium reduction ends. See the attached "*Summary of the COBRA Premium Reduction Provisions under ARRA*" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

### **When and how must payment for COBRA continuation coverage be made?**

#### *First payment for continuation coverage*

If you elect continuation coverage, you do not have to send any payment with the *Election Form*. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. If you do not make your first payment for continuation coverage in full by 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the issuer of your bill to confirm the correct amount of your first payment.

#### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. The amount due for each coverage month is included with this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the coverage month. If you make a periodic payment on or before the first day of the coverage month to which it applies, your coverage under the Plan will continue for that coverage period without any break. The COBRA billing administrator will provide information about how and where to submit your monthly premium payment.

#### *Grace periods for periodic payments*

Although periodic payments are due as described above, you will be given a grace period of 30 days after the first day of the coverage month to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. Your continuation coverage will be suspended if your premium is not received by the first of the coverage month, but any claims denied during that period may be resubmitted once premium payment is received before the end of the grace period. Payments are considered made when mailed.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the address noted on your billing statement.

### **For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. After your

initial enrollment, you may obtain additional information about COBRA by contacting:

Office of Health Benefits COBRA Administrator  
101 N. 14<sup>th</sup> Street  
13<sup>th</sup> Floor  
Richmond, VA 23219

For more information regarding COBRA coverage under the Public Health Service Act for state and local government employees, consult the U.S. Department of Health and Human Services—Centers for Medicare and Medicaid Services at [www.cms.hhs.gov/COBRAContinuationofCov/](http://www.cms.hhs.gov/COBRAContinuationofCov/) or [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).

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

In order to protect your and your family's rights, you should keep the Plan Administrator (Office of Health Benefits COBRA Administrator) informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Attachments: HIPAA Certificate of Creditable Coverage  
Extended Coverage Enrollment Form  
Summary of COBRA Premium Reduction Provisions under ARRA  
Request for Treatment as an Assistance Eligible Individual  
Participant Notification



## 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 the agency Benefits Administrator who provided this notice.

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 the Office of Health Benefits COBRA Administrator at 101 N. 14<sup>th</sup> Street, 13<sup>th</sup> Floor, Richmond, VA 23219.

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.cms.hhs.gov/COBRAContinuationofCov/](http://www.cms.hhs.gov/COBRAContinuationofCov/) or [www.dol.gov/COBRA](http://www.dol.gov/COBRA)

\* 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 along with your COBRA Continuation Coverage Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: Office of Health Benefits COBRA Administrator, 101 N. 14<sup>th</sup> Street, 13<sup>th</sup> Floor, Richmond, VA 23219.

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

## REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

### PERSONAL INFORMATION

(Full Version Election Notice)

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number (required) and e-mail address (optional)

Health Plan ID number or Social Security Number

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 4, you may still be eligible. If you are eligible for coverage as a retiree in the Commonwealth of Virginia Retiree Health Benefits Program, please indicate by checking this box . Eligibility for retiree coverage in the same plan that you had as an active employee may not prevent you from getting premium assistance if you were involuntarily terminated and, as a result, retired.**

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 → \_\_\_\_\_

### (Applicant should not complete this section) FOR DHRM 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 → \_\_\_\_\_

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 → \_\_\_\_\_

**ARRA Premium Assistance Recipients: keep this form and use it to notify your plan if you become eligible for other group health plan coverage or Medicare and, therefore, are no longer eligible for reduced premiums under ARRA. (You need not enroll in the other coverage to lose eligibility for premium assistance. Eligibility alone will cause loss of eligibility for premium assistance.)**

Commonwealth of Virginia  
Health Benefits Program  
Office of Health Benefits  
COBRA Administrator

**Participant Notification**

101 N. 14<sup>th</sup> Street  
13<sup>th</sup> Floor  
Richmond, VA 23219

**PERSONAL INFORMATION**

Name and mailing address

Telephone number (required) and e-mail address (optional)

ID number of Social Security No.

**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:

\_\_\_\_\_

\_\_\_\_\_