

APPLICATION FOR COBRA PREMIUM REDUCTION

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

To apply for ARRA Premium Reduction, complete this form and return it to:
CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, CA 95833-4235.

Please read the COBRA Premium Reduction notice that accompanied this Application for information about the COBRA premium reduction and the extended election period.

PERSONAL INFORMATION			
Name:			
Address:			
City:		State:	ZIP:
Telephone:		E-mail:	
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. Please specify the date of your termination:	<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 (i.e., medical, dental, and vision) (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. To elect COBRA, complete and return the enclosed COBRA election form to the Trust office at 2515 Venture Oaks Way, Suite 200, Sacramento, CA 95833-4235 within 60 days of the date of this notice.			
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 PLAN USE ONLY			
This application is: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Approved for some/denied for others (explain in #4 below)			
<i>Specify reason below and then return a copy of this form to the applicant.</i>			
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 Trust			
Signature:			Date:
Type or Print Name:			
Telephone:		E-mail:	

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)			
Name:		Birth Date:	
Relationship to Employee:		Social Security Number (Last 4)	
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 (i.e., medical, dental, and vision).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	I am NOT eligible for Medicare.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Signature:		Date:	
Type or Print Name:		Relationship to Employee:	

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Name:		Birth Date:	
Relationship to Employee:		Social Security Number (Last 4)	
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2.	I am NOT eligible for other group health plan coverage (i.e., medical, dental, and vision).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	I am NOT eligible for Medicare.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Signature:		Date:	
Type or Print Name:		Relationship to Employee:	

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Name:		Birth Date:	
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2.	I am NOT eligible for other group health plan coverage (i.e., medical, dental, and vision).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	I am NOT eligible for Medicare.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Signature:		Date:	
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