



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

### Request for Treatment as an Assistance Eligible Individual

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 Michael Tran at 860-676-1110 or by email at [Mitran@uchc.edu](mailto:Mitran@uchc.edu), 270 Farmington Avenue, Ste 352, Farmington, CT 06032.

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 Michael Tran at 860-676-1110 or by email at [Mitran@uchc.edu](mailto:Mitran@uchc.edu), Capital Area Health Consortium, 270 Farmington Avenue, Ste 352, Farmington, CT 06032.

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)

\* 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: Capital Area Health Consortium, 270 Farmington Avenue, Ste 352, Farmington, CT 06032 Attn: Michael Tran  
 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."

Capital Area Health Consortium  
 Group Health Plan

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

270 Farmington Ave,  
 Ste 352, Farmington,  
 CT 06032

**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.	Yes	No
3. I elected (or am electing) COBRA continuation coverage.	Yes	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).	Yes	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).	Yes	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.	Yes	No
2. I am NOT eligible for other group health plan coverage.	Yes	No
3. I am NOT eligible for Medicare.	Yes	No
4. The qualifying event was an involuntary termination or a reduction in hours.	Yes	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.	Yes	No
2. I am NOT eligible for other group health plan coverage.	Yes	No
3. I am NOT eligible for Medicare.	Yes	No
4. The qualifying event was an involuntary termination or a reduction in hours.	Yes	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.	Yes	No
2. I am NOT eligible for other group health plan coverage.	Yes	No
3. I am NOT eligible for Medicare.	Yes	No
4. The qualifying event was an involuntary termination or a reduction in hours.	Yes	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 → \_\_\_\_\_