

**To apply for ARRA Premium Reduction, complete this form and return it to us along with your Election Form.**

**You may also send this form in separately. If you choose to do so, fax the completed "Request for Treatment as an Assistance Eligible Individual" to the American Community Policy Administration Department at (734) 853-3276.**

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

Employer Name	<b>REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL</b>	Group #
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**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 loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**\*ADDITIONAL ELECTION PERIOD\***

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

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

**FOR EMPLOYER OR PLAN USE ONLY**

This application is:  Approved  Denied  Approved for some/denied for others (explain in #4 below)  
Specify reason below and then return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

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

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan  
→ \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

Telephone number → \_\_\_\_\_ E-mail address → \_\_\_\_\_