

Request for Treatment as an Assistance Eligible Individual

- To apply for a COBRA premium reduction under the American Recovery and Reinvestment Act of 2009 (ARRA), complete this form and return it with your completed *COBRA Continuation Coverage Election Form for Premium Reduction*. You may also want to read important information about your rights in the *Summary of the COBRA Premium Reduction Provisions Under ARRA*.
- Type or print clearly in black ink.

Section 1: SUBSCRIBER (EMPLOYEE) INFORMATION							
Social security number		Last name		First name		Middle initial	
Address						Apt./unit number	
City		State	ZIP Code	Daytime telephone number ()		Date of birth (mm/dd/yyyy)	
To qualify for a premium reduction, you must be able to check "yes" for all statements below.*							
1. The loss of employment was involuntary.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. The loss of employment occurred between September 1, 2008 and 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 #3 above, you may still be eligible under an additional COBRA election period. See back.*

Section 2: SPOUSE INFORMATION							
Social security number		Last name		First name		Middle initial	
Address (if different from subscriber)						Apt./unit number	
City		State	ZIP Code	Daytime telephone number ()		Date of birth (mm/dd/yyyy)	
To qualify for a premium reduction, you must be able to check "yes" for all statements below.*							
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	

**If you checked "No" for #1 above, you may still be eligible under an additional COBRA election period. See back.*

Section 3: DEPENDENT INFORMATION									
<i>Use additional forms for more dependents. List only eligible family members.</i>									
Social security number		Relationship to subscriber		Last name		First name		Middle initial	
Address (if different from subscriber)								Apt./unit number	
City		State	ZIP Code	Daytime telephone number ()		Date of birth (mm/dd/yyyy)			
To qualify for a premium reduction, you must be able to check "yes" for all statements below.*									
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	

**If you checked "No" for #1 above, you may still be eligible under an additional COBRA election period. See back.*

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Additional COBRA election period

If you (or the subscriber on this account) experienced an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA coverage **OR** you elected but later discontinued COBRA, you may qualify for an additional 60-day COBRA election period. You should receive a notice from the PEBB Program with a *Continuation of Coverage Election Notice* form, which you must complete and return. *If you believe you should have received this notice but didn't, please contact the PEBB Program at 1-800-200-1004.*

Section 4: SIGNATURES *Required*

I make an election to exercise my right to the COBRA premium reduction under the American Recovery and Reinvestment Act (ARRA). To the best of my knowledge and belief, all of the information I have provided on this form is true and correct.

HCA's Privacy Notice:

We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to www.hca.wa.gov.

Subscriber's signature _____ Date _____

Spouse's signature (if applying) _____ Date _____

Dependent's signature (if age 18+ and applying) _____ Date _____

Please sign and date this form.

Return to: Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

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