



IMPORTANT INFORMATION ABOUT YOUR RIGHT TO CONTINUATION COVERAGE WITH HEALTHPARTNERS

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 was signed into law by President Obama. This new law includes a 65 percent federal premium reduction for COBRA premiums for up to nine months for individuals who were involuntarily terminated from employment.

The premium reduction reduces the amount you would pay for continuation coverage by 65 percent. It is available for employees (and their eligible dependents) who were involuntarily terminated from employment from September 1, 2008 to December 31, 2009. The premium reduction is available for up to nine months beginning on or after March 1, 2009.

In order to meet our legal obligation to notify our members about this premium reduction, we are sending the enclosed notice to all individuals that were covered by HealthPartners through an employer with fewer than 20 employees and terminated coverage from September 1, 2008 to December 31, 2009.

Please note that you are only eligible for the premium reduction if you were involuntarily terminated from employment during the times specified above. You may be eligible for continuation coverage, but not the premium reduction – please see the grid below for more information. It is also possible that this information does not apply to you. **Please check the grid below to determine how this information applies to you.**

Reason for terminated coverage	Date of terminated coverage	State where employer is located	Did you elect continuation coverage?	Reference the enclosed forms marked with an “X” to determine eligibility		
				Form 1	Form 2	Form 3
Involuntary termination from employment	9/1/08 to 2/16/09	Minnesota	No election or election made but later dropped coverage		X	X
Involuntary termination from employment	9/1/08 to 2/16/09	Wisconsin	No election or election made but later dropped coverage	None – not eligible for premium reduction or special election <i>Pending action by the state government</i>		
Involuntary termination from employment	9/1/08 to 2/16/09	Minnesota, Wisconsin	Election made and coverage maintained			X
All COBRA-qualifying events other than involuntary termination from employment	9/1/08 to 2/16/09	Minnesota, Wisconsin	Election made and coverage maintained	None – not eligible for premium reduction		
Involuntary termination from employment	2/17/09 to 12/31/09	Minnesota, Wisconsin	If you haven’t already, coverage must be elected in the allowed timeframe	X		X
All COBRA-qualifying events other than involuntary termination from employment	2/17/09 to 12/31/09	Minnesota, Wisconsin	If you haven’t already elected coverage, you must do so in the allowed timeframe	X	Not eligible for premium reduction	
A reason other than what is noted in this table	9/1/08 to 12/31/09	Minnesota, Wisconsin	N/A	Please disregard this notice		



Depending on the location of the employer, you have different rights for continuation coverage:

- **Minnesota-based employers**

- If your employer is located in Minnesota and you're eligible for continuation coverage, you can elect coverage for both medical and dental coverage as long as you had coverage on the day before your employment ended.
- If you were involuntarily terminated between September 1, 2008 and February 16, 2009 and you previously declined or dropped continuation coverage, you have an opportunity to re-elect coverage.
- Please note that if your employment ended as a result of involuntary termination from September 1, 2008 to February 16, 2009 and you elect continuation coverage during the special election period, your coverage, premium and premium reduction must begin on March 1, 2009.

- **Wisconsin-based employers**

- If your employer is located in Wisconsin and you're eligible for continuation coverage, you can only elect continuation coverage for your medical coverage as long as you had coverage on the day before your employment ended.
- Please reference the grid on the previous page to determine your eligibility for coverage and the premium reduction.

Note: If you were covered on a health plan of someone other than yourself, "the employer" refers to the employer for the policy holder.

The premium reduction is 65 percent of the amount you normally pay for your coverage. So, if you qualify for the premium reduction, you will be billed 35 percent of what you would normally be billed.

You cannot receive reimbursement for premiums for continuation coverage prior to March 1, 2009, but if you already paid the full premium for coverage after March 1, 2009 and you are eligible for the premium reduction, you will be credited for any amount you over-paid once you correctly complete and submit the required paperwork to your employer or their COBRA administrator. Please note that incomplete or incorrectly completed paperwork will result in a delay.

Please note that you are no longer eligible for the premium reduction on the date you become eligible for other health plan coverage. You must notify your employer of this eligibility or you could face tax penalties.

You may also receive similar information from your employer. If you're not sure what information you need to complete, please contact your employer or their COBRA administrator. For more information about the premium reduction, please visit www.dol.gov/COBRA.

Form 1

Continuation Coverage Election Notice



Dear qualified beneficiary,

This notice contains important information about your right to continue your healthcare coverage with HealthPartners. Please read the information in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of medical and/or dental coverage that occurred during the period that begins September 1, 2008 and ends December 31, 2009 may be eligible for the 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, reference the “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.”

If you believe you meet the criteria for the premium reduction, please also complete Form 3, the “Request for Treatment as an Assistance Eligible Individual” and return it with your completed Election Form to your employer or their COBRA administrator.

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to your employer or their COBRA administrator.

If you do not elect continuation coverage, your coverage under HealthPartners will end on the last day of the month in which your termination event occurred due to:

Check the appropriate box(es)

- End of employment
 - Involuntary
 - Voluntary
- Divorce or legal separation
- Death of employee
- Entitlement to Medicare
- Reduction in hours of employment
- Loss of dependent child status

Each person in one or more of the categories checked below is entitled to elect continuation coverage, which will usually continue group healthcare coverage under the plan for the noted time period.

Check the appropriate box

- Employee or former employee – 18 months
- Spouse or former spouse – varies depending on the qualifying event
- Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage – varies depending on the qualifying event
- Child who is losing coverage under the plan because he or she is no longer a covered dependent – 36 months

Form 1

Continuation Coverage Election Notice



If you are eligible and coverage is elected, your continuation coverage will begin on the date you lost your coverage due to a qualifying event.

You may elect the following options for continuation coverage if you were enrolled in the coverage on the day prior to your qualifying event:

- HealthPartners Medical Plan
- HealthPartners Dental Plan (not available if your employer is based in Wisconsin)

To find out how much your continuation coverage will cost, please contact your employer or their COBRA administrator.

If you qualify as an “Assistance Eligible Individual” this cost can be reduced by 65 percent for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, please contact your employer or their COBRA administrator.

Form 1

Continuation Coverage Election Notice



Instructions: To elect continuation coverage, complete this Election Form and return it to your employer or their COBRA administrator. By law, you have 60 days after the date of your first continuation notice to decide whether you want to elect continuation coverage.

Send completed Election Form to your employer or their COBRA administrator. This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than 60 days after the date of your first continuation notice.

If you do not submit a completed Election Form by the due date, you will lose your right to elect continuation coverage. If you reject 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 continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage as indicated below:

Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options: <input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan			
Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options: <input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan			
Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options: <input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan			

If you have additional qualified beneficiaries, please attach a separate sheet of paper with the information requested above.

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

Form 1

Continuation Coverage Election Notice



Important information about your continuation coverage rights

What is continuation coverage?

State law requires that most employers give employees and their families the opportunity to continue their 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 you had with your employer on the day before the qualifying event. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

How long will continuation coverage last?

The length of continuation coverage varies depending on the qualifying event. Please contact your employer or their COBRA administrator for specific information about your coverage.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it to your employer or their COBRA administrator.

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 pre-existing 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 pre-existing condition exclusion if you do not elect continuation coverage for the maximum time available to you. 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 the qualifying event listed above. 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 continuation coverage cost?

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage 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. If you qualify for the premium reduction, you only need to pay 35 percent of the continuation coverage premium otherwise due to your employer. This premium reduction is available for up to nine months. See the attached “Summary of the Continuation Coverage 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 continuation coverage be made?

Please contact your employer or their COBRA administrator to confirm the correct amount of your first payment and/or to discuss payment issues related to the ARRA premium reduction. Your payment(s) for continuation coverage should be sent to your employer or their COBRA administrator.

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from your employer or their COBRA administrator

Keep your plan informed of address changes

In order to protect your and your family’s rights, you should keep your employer or their 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 your employer or their COBRA administrator.



Dear qualified beneficiary,

This notice contains important information about your right to continue your healthcare coverage with HealthPartners. Please read the information in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of medical and/or dental coverage that occurred between September 1, 2008 and December 31, 2009 may be eligible for the temporary premium reduction for up to nine months.

If you were involuntarily terminated from employment with an employer based in Minnesota between September 1, 2008 and February 16, 2009, you have an opportunity to elect continuation coverage if you previously declined coverage or had coverage and then dropped it. If you choose to elect coverage, your coverage, premiums and premium reduction must begin on March 1, 2009.

To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.”

If you believe you meet the criteria for the premium reduction, please also complete Form 3, the “Request for Treatment as an Assistance Eligible Individual” and return it with your completed Election Form to your employer or their COBRA administrator.

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to your employer or their COBRA administrator.

Each qualified beneficiary in the category(ies) checked below is entitled to elect COBRA continuation coverage, which generally will continue group healthcare coverage under for up to 18 months after an involuntary termination of employment.

Check the appropriate box(es)

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under by the plan on the day before the involuntary termination of employment (and any new dependents born, adopted or placed for adoption between the date coverage was lost and February 17, 2009)

You may elect the following options for continuation coverage if you were enrolled in the coverage on the day prior to your qualifying event:

- HealthPartners Medical Plan
- HealthPartners Dental Plan (not available if your employer is based in Wisconsin)

Form ②

Continuation Coverage Special Election Notice



To find out how much your continuation coverage will cost, please contact your employer or their COBRA administrator.

If you qualify as an “Assistance Eligible Individual” this cost can be reduced by 65 percent for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, please contact your employer or their COBRA administrator.

Form 2

Continuation Coverage Special Election Notice



Continuation Coverage Special Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to your employer or their COBRA administrator. By law, you have 60 days after the date of your first continuation notice to decide whether you want to elect continuation coverage.

Send completed Election Form to your employer or their COBRA administrator. This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than 60 days after the date of your first continuation notice.

If you do not submit a completed Election Form by the due date, you will lose your right to elect continuation coverage. If you reject 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 continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage as indicated below:

Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options: <input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan			
Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options: <input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan			
Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options: <input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan			

If you have additional qualified beneficiaries, please attach a separate sheet of paper with the information requested above.

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number



Important information about your COBRA continuation coverage rights

Am I eligible to elect COBRA continuation coverage at this time?

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect COBRA continuation coverage during their first election period OR who elected but subsequently discontinued COBRA coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect COBRA continuation coverage when it was first offered, you are not entitled to this second election period.

Am I eligible for the premium reduction?

If you lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below under the question, "How much does COBRA continuation coverage cost?"

How long will continuation coverage last?

Your coverage will begin retroactively March 1, 2009 and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your COBRA coverage. See the question below entitled "How much does COBRA continuation coverage cost?"

Continuation coverage will be terminated before the end of the 18 month period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary 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).

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 your employer or their 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. Please contact your employer or their COBRA administrator if you would like more information.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries 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. The disabled person must notify the group health plan sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. 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, you must notify the Plan of that fact within 30 days after that determination.

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 or separation from the covered employee, the covered employee's becoming entitled to



Medicare benefits (under Part A, Part B, or both), 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 of a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. 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. If you do elect continuation coverage under this additional election period, the period from qualifying event to the date coverage begins under your election will not count as a break in coverage in determining whether you had a 63-day break in coverage.

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 described in 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. 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 continuation coverage. 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 continuation coverage be made?

Please contact your employer or their COBRA administrator for information on your first payment for continuation coverage, periodic payments for continuation coverage and grace periods for periodic payment. Your payment(s) for continuation coverage should be sent to your employer or their COBRA administrator.

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from your employer or their COBRA administrator

Keep your plan informed of address changes

In order to protect your and your family's rights, you should keep your employer or their 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 your employer or their COBRA administrator.



Summary of the Continuation Coverage 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 continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to nine 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.*

◆ 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 your employer or their COBRA administrator in writing immediately. 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.

For information related to your plan’s administration of continuation coverage, the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, contact your employer or their COBRA administrator.

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 -or- 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 to your employer or their COBRA administrator along with your Election Form.

If you already have continuation coverage, 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 your employer or their COBRA administrator.

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

Employer Name

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

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) 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 |

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 USE ONLY

To be completed before sending to HealthPartners

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 continuation coverage within the allowable timeframe. | <input type="checkbox"/> |
| 4. Other (please explain) | <input type="checkbox"/> |

Signature of party responsible for continuation coverage administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

Form 3

Attestation for ARRA Premium Reduction

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) 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) 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) 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 → _____

This form is designed for issuers to distribute to qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the issuer if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your issuer that you are eligible for other group health plan coverage or Medicare.

Employer Name

Participant Notification

PERSONAL INFORMATION

Name and mailing address

Telephone number

E-mail address (optional)

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 issuer of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced continuation coverage 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:
