



Application for Treatment as an Assistance Eligible Individual

To apply for the American Recovery and Reinvestment Act (ARRA) Premium Reduction, complete this form and return it to your former Health Benefits Representative.

PERSONAL INFORMATION

Record your name and mailing address here	Telephone Number
	ID Number

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 May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am electing COBRA continuation through the ARRA Premium Reduction Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am electing COBRA continuation coverage through the ARRA Premium Reduction Plan as a result of a reduction in hours which occurred between September 1, 2008 and May 31, 2010, which was followed by an involuntary loss of employment which occurred on or after March 2, 2010 and by May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am eligible for and electing to continue my coverage through RIF benefits and I am declining COBRA continuation through the ARRA Premium Reduction Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I am eligible for and electing to continue my coverage through RIF benefits and my qualified dependent(s) are electing COBRA continuation through the ARRA Premium Reduction Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. I am eligible for other group health plan coverage or Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. I am electing regular COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Employee Signature: _____ Date: _____

Type or print name: _____

List dependents to be covered below and on the back.

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

A	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)

1. I am a qualified beneficiary and electing COBRA continuation through the ARRA Premium Reduction Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am eligible for other group health plan coverage or Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am electing to continue coverage through RIF benefits.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am a qualified beneficiary and electing regular COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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: _____

B	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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1. I am a qualified beneficiary and electing COBRA continuation through the ARRA Premium Reduction Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am eligible for other group health plan coverage or Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am electing to continue coverage through RIF benefits.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am a qualified beneficiary and electing regular COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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: _____

C	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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1. I am a qualified beneficiary and electing COBRA continuation through the ARRA Premium Reduction Plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am eligible for other group health plan coverage or Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am electing to continue coverage through RIF benefits.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am a qualified beneficiary and electing regular COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

This application is:

- Approved for RIF benefits Approved for COBRA, Denied for ARRA Premium Reduction Plan
 Approved for ARRA Premium Reduction Plan Denied for ARRA Premium Reduction Plan, specify reason below

Return a copy of this form to the applicant, keep a copy to meet your reporting requirements and send a copy to NC State Health Plan, Attention: State Membership Services, PO Box 30111, Durham, NC 27702.

REASON FOR DENIAL AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The involuntary loss did not occur between September 1, 2008 and May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The qualifying event was a reduction of hours and was not followed by a termination of employment or the termination occurred prior to March 2, 2010 or after May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Other (please explain):	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of employer: _____ Date: _____

Type or print name: _____

Telephone Number: _____ E-mail address: _____