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

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®[1], 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:

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:

For more information regarding ARP premium assistance and eligibility questions, visit:

www.dol.gov/cobra-subsidy or contact the Department of Labor at askebsa.dol.gov or 1-866-444-EBSA (3272)

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* This restriction does not include coverage under a plan that provides only excepted benefits, a qualified small employer health reimbursment arrangement, or coverage under a health flexible spending arrangement.

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

COBRA Continuation Conversion Supplemental Notice

This notice contains important information about your right to continue your health care coverage in the Plan(s) identified in the cover letter you received with this notice from your employer.

Please read the information contained in this notice very carefully.

The American Rescue Plan (ARP) Act of 2021 reduces your COBRA premium cost. You are receiving this election notice because:

- You experienced a loss of coverage that occurred during the period that begins with April 1, 2021 through September 30, 2021 and you may be eligible for the temporary premium reduction for up to six months. *or*
- You experienced a loss of coverage at some time from November 1, 2019 through September 30, 2021. If your loss of coverage was due to an involuntary termination of employment, you may be eligible for a second COBRA election opportunity and the temporary premium reduction for up to six months. If elected, COBRA continuation coverage begins retroactively on April 1, 2021.

To help determine whether you can get the ARP premium subsidy, you should read this notice and these documents carefully. In particular, reference the “Summary of the COBRA Premium Reduction Provisions under ARP” with details regarding eligibility, restrictions, and obligations and the “Application for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “Application for Treatment as an Assistance Eligible Individual” and return it with your completed form.**

To elect COBRA continuation coverage, follow the instructions in the previous pages and this notice. Refer to the continuation election form(s) that you received from your employer for any plan(s) for which you are eligible for COBRA continuation coverage. The form(s) list(s) the qualifying event that makes you eligible for COBRA continuation coverage, the date your coverage under the plan(s) will end if you do not elect COBRA continuation coverage, and the qualified beneficiary(ies) eligible to elect COBRA continuation coverage.

If elected, COBRA continuation coverage begins on the date following the coverage end date indicated on your continuation election form(s), unless otherwise noted above, and can last up to 36 months.

To change the coverage option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment, list the new plan option when completing the application. The new plan option must cost the same or less than the coverage you had on your last day of employment.

COBRA continuation coverage will cost:

Plan	Total Monthly Premium
Health Insurance (plan)	$
Dental Insurance (plan)	$
Vision Insurance (plan)	$
Other Insurance (plan)	$

If you qualify as an “Assistance Eligible Individual” the monthly cost will be zero.

You do not have to send any payment with the application. Important additional information about payment for COBRA continuation coverage is included in this notice.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact us at:

Request for Treatment as an Assistance Eligible Individual

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

To apply for ARP premium reduction, complete this form and return it to your former employer along with your completed continuation election form(s). If you are changing coverage type or plan options, you will also need to submit a completed application form. If you are electing continuation coverage for any of the optional plans, such as dental, you must complete and submit the continuation election form for that plan.

Section A: Employee Information - List dependent information on back.

Name (First, Middle Initial, Last)	ETF ID or Last 4 digits of SSN
Mailing Address	Telephone, including area code

Section B: Eligibility - To be eligible, you must be able to check Yes for all statements*

Statement	Answer
1. The loss of employment was involuntary.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after November 1, 2019 and on or before September 30, 2021.	☐ 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 coverageduring the period for which I am claiming a reduced premium).	☐ Yes ☐ No
5. I am *not* eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming areduced premium).	☐ Yes ☐ No

If you checked No for statement 3, you may still be eligible if you qualify for an additional election period.** If your COBRA continuation coverage relates to an involuntary loss of employment from November 1, 2019 through September 1, 2021 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 that you must complete and return. If you believe you should have received this additional notice but have not, contact your former employer at the phone number listed on the letter that was sent with this form.

Section C: Applicant Signature

I make an election to exercise my right to the ARP premium reduction. I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

Name	Relationship to employee
Signature	Date (MM/DD/YYYY)

For Employer Use Only – Return copy of completed form to the applicant

Date Employment Terminated _____

Coverage(s) in effect at time of termination: ☐ Health ☐ Dental ☐ Vision ☐ Other _____

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

If Denied, Reason For Denial Of Treatment As An Assistance Eligible Individual

1. Loss of employment was voluntary. ☐
2. The involuntary loss did not occur between November 1, 2019 and September 30, 2021. ☐
3. Individual did not elect COBRA coverage.* ☐
4. Other (please explain) ☐ _____

***If you checked number 3, was individual eligible for, and given, the additional election period described above?**

Name of employer/plan admin/party responsible for COBRA plan administration	Email address	
Signature	Telephone, inc. area code	Date (MM/DD/YYYY)

Section D: Dependent Information

If applying for family coverage, complete the information for each eligible dependent. Attach additional copies of this form if you have more than 4 eligible dependents. *(Parent or guardian should sign for minor children.)*

Dependent name (First, MI, Last)	**Birth date**	**Last 4 digits of SSN**	**Relationship to employee**

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

I make an election to exercise my right to the ARP premium reduction. I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

Signature____ Date (MM/DD/YYYY) ______________

Type or print name____

Dependent name (First, MI, Last)	**Birth date**	**Last 4 digits of SSN**	**Relationship to employee**

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

I make an election to exercise my right to the ARP premium reduction. I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

Signature____ Date (MM/DD/YYYY) ______________

Type or print name____

Dependent name (First, MI, Last)	**Birth date**	**Last 4 digits of SSN**	**Relationship to employee**

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

I make an election to exercise my right to the ARP premium reduction. I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

Signature____ Date (MM/DD/YYYY) ______________

Type or print name____

Dependent name (First, MI, Last)	**Birth date**	**Last 4 digits of SSN**	**Relationship to employee**

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

I make an election to exercise my right to the ARP premium reduction. I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

Signature____ Date (MM/DD/YYYY) ______________

Type or print name____

Participant Notification

Keep this form. If you are approved for the premium assistance, you must notify your former employer and your plan if you become eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARP. To notify your former employer and plan, complete and submit this form.

Failure to provide this notice may subject you to a tax penalty.

Section A: Personal Information	
Name (First Name, Middle Initial, Last Name)	ETF ID or Last 4 digits of SSN
Mailing Address	Telephone, including area code

Section B: Premium Reduction Ineligibility Information (Check One)

I am eligible for coverage under another group health plan. ☐

Date you become eligible (MM/DD/YYYY): ____________

If any dependents are also eligible, list their names:

I am eligible for Medicare. ☐ Date you become eligible (MM/DD/YYYY): ____________

Important: If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare and continue to receive COBRA subsidy, you could be subject to a fine.

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.

Section C: Signature

I make an election to exercise my right to the ARP premium reduction. I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

Name	
Signature	Date (MM/DD/YYYY)

Section D: Dependent Information

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here: