U. S. Department of Labor
Employee Benefits Security Administration
Washington, DC 20210

{Insert Date}

Plan Administrator

Re: Application for Expedited Review of Denial of COBRA Premium Reduction
**Applicant's name: [First Name] [Last Name]**
**Employee name: [First Name] [Last Name]**
**Control number: [Record number]**

Dear Plan Administrator:

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act (2010 DOD Act) on December 19, 2009 and the Temporary Extension Act of 2010 (TEA) on March 2, 2010, provides for premium reductions for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. The premium assistance is also available for continuation coverage under certain State laws. "Assistance Eligible Individuals" pay only 35 percent of their COBRA premiums; the remaining 65 percent is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for up to 15 months.

To be considered an "Assistance Eligible Individual" and receive reduced premiums you:
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- MUST have a continuation coverage election opportunity (qualifying event)* related to an involuntary termination of employment that occurred at any time from September 1, 2008 through March 31, 2010;
- MUST elect the coverage (within the appropriate timeframes);
- 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.

*TEA also provides that individuals who lost coverage because of a qualifying event that was a reduction of hours that occurred any time from September 1, 2008 through March 31, 2010 may be eligible for the premium reduction if the employee is then involuntary terminated on or after March 2, 2010 and no later than March 31, 2010. The premium assistance for these individuals begins with the first period of coverage following the employee's termination (that occurs on or after March 2, 2010 through March 31, 2010). TEA also provides a new election opportunity for these individuals if they did not elect (or elected and discontinued) COBRA. [A reduction of hours qualifying event occurs when the employee and his/her family lose coverage because the employee's hours were reduced or the employee is no longer working enough hours required by the plan to maintain the group health coverage although they are still employed. ]

The applicant (person requesting review of a denial of premium assistance) may either be the former employee or a member of the employee's family who is eligible for COBRA continuation coverage or the COBRA premium assistance through an employment-based health plan. The employee and his/her family members may each elect to continue health coverage under COBRA, request the premium assistance, and request a review of a denial of premium assistance.

We have received an application for expedited review from the individual named above who claims to have been denied premium reduction in connection with COBRA continuation coverage under your plan. In order to make a determination regarding this person's eligibility for COBRA continuation coverage and the ARRA COBRA premium reduction, we need information from you regarding the individual's coverage under the plan and the circumstances related to the job loss which gave rise to the COBRA eligibility. The ARRA statute requires the determination to be made within 15 business days of receipt of the individual's request; therefore, we ask that you complete the information below and return it to us within 2 business days. *If we do not receive this information within that time period, the determination may have to be made solely on the basis of the information provided by the individual.*

Please complete the attached form and submit it electronically by going to the COBRA page at www.dol.gov/COBRA and clicking on the first link under "For Employers". You may also send us the information and any attachments using the attached Bar Code Cover page by fax or mail to:

Fax to: U.S. Department of Labor, EBSA
Attn: COBRA Appeals
Fax number: (202) 693-8849 *(not toll-free)*

Mail to: U.S. Department of Labor, EBSA
Attn: COBRA Appeals
P.O. Box 78038
Washington, DC 20013-9038

Please put the Control number (above) on all correspondence. If you need assistance, please call a COBRA appeals unit representative toll-free at (877) 522-7880.

Sincerely,

Cobra Appeals Processing Unit

Attachments

**Plan Sponsor/Plan Administrator Information Sheet**
**OMB Control Number 1210-0135 Exp. Date: 11/30/2012**

**Control number: [Record Number]**
**Applicant's name: [First Name] [Last Name]** **Employee name: [First Name] [Last Name]**

Date of employee's job termination: ____/_____/____ Date of termination of benefits: _____/_____/____

Please indicate whether the applicant was denied COBRA continuation coverage or the ARRA COBRA Premium Reduction and check the reason for the denial below:

Not denied, the applicant has been provided with or will be provided with COBRA continuation coverage and the ARRA COBRA premium reduction.

Please enter the date the applicant's request was approved: _____/_____/_____

☐ Denied because the qualifying event was not the employee's involuntary termination of employment. Please enter any pertinent details regarding the circumstances of the employee's termination in the comment section below. (For help in determining what job loss situations are involuntary terminations, see IRS Guidance at www.dol.gov/COBRA.)

☐ Denied because the employee's job loss did not occur during the period from September 1, 2008 through March 31, 2010.

Denied because the applicant was eligible for other group coverage or Medicare. (Please provide comments below indicating information about the coverage you believe he/she was eligible for.)

☐ Denied because the applicant did not pay for COBRA timely. (Please provide details regarding the non-payment or late payment below.)

Denied because the applicant was not covered by the group health plan on the day before the qualifying event, and was not a new dependent (or dependents) by birth, adoption, or placement for adoption (and was not eligible for an Extended Election Period).

Denied because the applicant did not elect COBRA continuation coverage (either at the first opportunity or under any Extended Election period).

Denied because the employee was dismissed for gross misconduct. The applicant was / was not (circle one) offered COBRA continuation coverage. *If claiming the employee was dismissed for gross misconduct, please provide detailed information regarding the alleged conduct in the comment section below and by attaching additional pages (such as termination paperwork, copies of investigations, etc.).*

Denied because the employer is exempt from COBRA under the small employer exemption (*see information below*).

The rules regarding whether an employer is exempt from COBRA under the small-employer exception can be complex. Generally, COBRA only applies to group health plans maintained by employers that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

If exempt under the small employer exception, is the plan fully insured and subject to state continuation coverage? Yes No Unsure

☐ Denied because the employer no longer sponsors a group health plan. Please check the box or enter the date as appropriate:

The employer never sponsored a group health plan.

The employer sponsored a health plan, but it was terminated effective ____/____/_____

If you no longer sponsor a group health plan, is there another entity* that may be liable to provide COBRA continuation coverage to the participants and beneficiaries?

Yes No Unsure

If yes, please enter the name, address and contact information for that entity in the comment section below as well as a brief description of the circumstances that you believe makes them liable to provide COBRA continuation coverage.

*Please note: under special rules, if your company was acquired by another business that provides group health benefits, the acquiring business may have successor liability and a duty to offer COBRA continuation coverage to participants and beneficiaries. Additionally, all of COBRA's requirements apply to employers on a "controlled group" basis as defined in the Internal Revenue Code. These rules may require employers in a "parent-subsidiary" or "brother-sister" relationship as measured by an ownership test to provide COBRA benefits. If you acquired or were acquired by another business, or your business is part of a control group, you may want contact EBSA toll free at 1-866-444-3272 to speak to a Benefits Advisor for assistance in determining whether you or another entity may need to provide COBRA continuation coverage.

Denied for other reason(s), please explain (attach additional pages if needed):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

*Under penalty of perjury, I declare that the information completed above and any accompanying attachments are true, correct and complete to the best of my knowledge and belief.*

Signature: _______________________________________ Date:________________________

Type or print name: _______________________________________________________________

Address, if different from above:

______________________________________________________________________________

Phone number: ____________________ Fax number: _________________________

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average one (1) hour per response, including time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain benefit (*see* section 3001(a)(5) of the American Recovery and Reinvestment Act, P.L. 111-5, as amended by the Department of Defense Appropriations Act, 2010, P.L. 111-118 and the Temporary Extension Act of 2010, P.L. 111-144). Please send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 and reference OMB Control Number. **Note**: Please do not return the completed application to this address.