

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:

- ◆ 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 Mail to: U.S. Department of Labor, EBSA

Attn: COBRA Appeals Attn: COBRA Appeals

Fax number: (202) 693-8849 (not toll-free) 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

	ol number: [Record : cant's name: [First N		nme] Em	ployee name: [Fi	rst Name] [Last Na	ame]	
Date of	f employee's job term	ination:	//	_ Date of terminati	on of benefits:	/	_/
	indicate whether the a				verage or the ARRA	A	
	Not denied, the appl continuation coverage						
	Please enter the date	the applicant'	s request was	s approved:/	//		
	Denied because the Please enter any per comment section be see IRS Guidance at	tinent details re low. (For help	egarding the in determini	circumstances of tl	he employee's term	ination i	n the
	Denied because the March 31, 2010.	employee's job	loss did not	occur during the p	period from Septeml	ber 1, 20	008 through
	Denied because the comments below inc						
	Denied because the payment or late pay		ot pay for Co	OBRA timely. (Ple	ease provide details	regardir	ng the non-
	Denied because the event, and was not eligible for	new depender	it (or depend	ents) by birth, adop			
	Denied because the or under any Extend			RA continuation o	coverage (either at tl	he first o	pportunity
	Denied because the one) offered COBR misconduct, please please below and by attach	A continuation provide detaile	coverage. <i>If</i> d information	claiming the empl regarding the all	loyee was dismissed eged conduct in the	l for gros commer	ss nt section
	Denied because the employer is exempt from COBRA under the small employer exemption (<i>see information below</i>).						
	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 coverage?	small employe Zes	r exception, No	is the plan fully ins Unsure	sured and subject to	state co	ntinuation

date as	s 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.
Denied	*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.
	of perjury, I declare that the information completed above and any accompanying attachments are and complete to the best of my knowledge and belief.
Signature:	Date:
Type or print r	name:
Address, if dif	ferent from above:
Phone number	: Fax number:
According to the	duction Act Statement Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless displays a valid OMB control number. Public reporting burden for this collection of information is estimated.

Denied because the employer no longer sponsors a group health plan. Please check the box or enter the

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.