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

Control number: XXX
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 May 31, 2010.

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.

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: _____

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