Print Form

Application to the U. S. Department of Labor for Expedited Review of Denial of COBRA Premium Reduction

GENERAL INFORMATION: If you or a family member has lost employment, a new law may make it possible for you to keep your employment-related health coverage. The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium assistance 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. For coverage periods beginning on or after February 17, 2009, assistance eligible individuals pay only 35% of their continuation coverage premiums to the plan for the first nine months. The remaining 65% is reimbursed to the plan, employer, or health insurance issuer through a payroll tax credit.

To be eligible for assistance, you must meet ALL of the following requirements:

- Be eligible for continuation coverage under COBRA or a State law that provides comparable continuation coverage (for example, so-called "mini-COBRA" laws) at any time during the period beginning September 1, 2008 and ending December 31, 2009;
- Elect continuation coverage (when first offered or during the additional election period); and
- Have a qualifying event for the continuation coverage that is the employee's involuntary termination during the period beginning September 1, 2008 and ending December 31, 2009.

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.

If you believe you are eligible for COBRA continuation coverage and for this premium reduction through a private sector health plan sponsored by an employer generally with at least 20 employees, but your request for these benefits or the reduced premium has been denied, you may apply to the U.S. Department of Labor to review the denial. If your continuation coverage is provided through a Federal, State or local government plan, or if it is provided pursuant to State insurance law, you should direct your request for review to the Department of Health and Human Services or access their website at www.cms.hhs.gov/COBRAContinuationofCov/.

APPLYING FOR REVIEW: Answer all of the questions on the application to the best of your knowledge and ability. If you don't know the answer to a question you may check the box marked "Unsure or N/A." (N/A stands for "not applicable.") The red asterisk (*) denotes required information. Please include copies of any documents that you think would help the Department in its review of your application, examples of which are listed in the attached instructions. Provide your complete contact information (daytime phone number, an alternate phone number, and an email address, if available) so that the person reviewing your application can contact you with any questions or if additional information is needed. The Department of Labor will not review your denial until you submit a properly completed application form. A separate application(s) must be completed for any family member whose plan information is not identical to the information you provide. Keep a copy of the application(s) submitted for your records. NOTE: In the course of its review, the Department may need to share information on this application with your employer or plan administrator.

You are encouraged to complete your application online at www.dol.gov/COBRA or, you can fax or mail this completed application, along with your attachments, to:

Fax to: U.S. Department of Labor, EBSA
Attn: COBRA Appeals
Fax number: 202-693-8849

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

FOR ASSISTANCE: If you have questions on how to complete this form or about eligibility for COBRA or the COBRA premium reduction, please see our website at www.dol.gov/COBRA. You may also call a DOL Benefits Advisor toll-free at 1-866-444-3272. Benefits Advisors can assist you with questions, but cannot complete or take your application for review by phone.

Attention: Before you get started, do a quick check on your eligibility for the COBRA premium reduction.

If –

- √ you were covered by the employer's group health plan on the last day of the employee's employment*;
- √ there is an ongoing health plan responsible for providing COBRA continuation coverage;
- √ the employee's job termination was involuntary** and occurred during the period beginning September 1, 2008 through December 31, 2009; and
- √ you are eligible for COBRA at any time during that period due to the employee's job loss and not divorce, legal separation, entitlement to Medicare, loss of dependent status, or death of the covered employee,

then you may be eligible for the COBRA premium reduction.

If you have questions on how to complete this application or about eligibility for COBRA or the COBRA premium reduction, please see our website at www.dol.gov/COBRA. You may also call a DOL Benefits Advisor toll-free at 1-866-444-3272. If you feel that you have been inappropriately denied the COBRA premium reduction, complete the attached application.

* Note: newborns, adopted children or children placed for adoption added through special enrollment count as if they were on the plan on the last day of the employee's employment.

** For help in determining what job loss situations are involuntary terminations, see the IRS guidance at ww.irs.gov/pub/irs-drop/n-09.27.pdf.

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OMB Control Number 1210-0135 Exp. Date 11/30/2009

Applicant's Information

* Denotes required information

*Name Mr. ☐ Mrs. ☐ Ms. ☐

Last First Middle Initial

*Street Address

*City State Zip code

*Best phone number to reach you during business hours: Home ☐ Work ☐ Cell ☐

Alternate phone number: Home ☐ Work ☐ Cell ☐

Email Address:

*Date employment was terminated: (month/day/year) / /

Date of termination of insurance or group health plan benefits, if any: (month/day/year) / /

Applicant's relationship to employee: Self ☐ Spouse ☐ Child ☐ Other (explain) ☐

If applicant is not the employee, provide name of employee:

*Name Mr. ☐ Mrs. ☐ Ms. ☐

Last First Middle Initial

Names of dependents for whom you are also requesting a determination regarding a denial of COBRA premium reduction, if any. **Reminder:** If the plan information for any family member is not identical to your information, complete a separate application for them.

Name	Relationship	Age
D1)		
D2)		
D3)		
D4)		

Attach an additional page if you need to add more dependents to the list

Eligibility: Please see instructions for assistance in answering the questions below.	**Yes**	**No**	**Unsure or N/A**
*1. On the last day of your or your family member's employment, were you covered by a group health plan at work? If you acquired a new dependent (or dependents) by birth, adoption or placement for adoption, refer to the instructions to answer the question for your new dependent.	☐	☐	☐
*2. Did the employee's job termination occur from September 1, 2008 through December 31, 2009.	☐	☐	☐

	Yes	No	Unsure or N/A
*3. Is there an ongoing health plan that covers employees where you or your family member used to work? Note: The plan could be sponsored by the former employer, union or joint board of trustees or another employer who may be responsible for providing COBRA continuation coverage to you.	☐	☐	☐
*4. Are you eligible for COBRA because of your or your family member's job loss? If so, answer YES. If you are eligible for COBRA because of divorce, legal separation, entitlement to Medicare, loss of dependent status, or death of the covered employee, answer NO.	☐	☐	☐

PLEASE NOTE: If you answered NO to any of the Questions above (1-4) you may not be eligible for the COBRA premium reduction. If you have questions about the requirements for COBRA or for the COBRA premium reduction, or otherwise need assistance completing this application, please contact a Benefits Advisor toll-free at 1-866-444-3272.

	Yes	No	Unsure or N/A
*5. Was your or your family member's job termination involuntary?	☐	☐	☐
a. Was it a permanent layoff?	☐	☐	☐
b. Was it a layoff with possible recall or a temporary furlough?	☐	☐	☐
c. Was it a buyout or severance package in anticipation of a layoff?	☐	☐	☐
d. Did the employee resign as a result of a change in the geographic location of employment?	☐	☐	☐
e. Did the employee's employment end while the employee was absent due to illness or disability?	☐	☐	☐
f. Other - please describe in the **Other Information** box at the end of the application.	☐	☐	☐
For more information that may help you to answer these questions, see Questions 1-9 of the IRS Notice 2009-27 at www.irs.gov/pub/irs-drop/n-09-27.pdf.			
*6. Did you or your family member work for the Federal government, a State or local government, or a church?	☐	☐	☐
*7. Do you believe that your or your family member's former employer had 20 or more employees in the calendar year prior to the employee's job termination?	☐	☐	☐
*8. Regarding COBRA coverage: a. Did you receive a notice informing you of your right to elect COBRA? b. Did you send in a form requesting, or electing, COBRA coverage? c. Were you denied COBRA coverage? If yes, explain the reason in the **Other Information** box at the end of the application. Attach copies of all relevant documents.	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
*9. Regarding the COBRA premium reduction: a. Did you receive a notice informing you of your right to a premium reduction? b. Were you denied the premium reduction? If yes, explain the reason in the **Other Information** box at the end of the application below. Attach copies of all relevant documents.	☐ ☐	☐ ☐	☐ ☐
*10. At any time after you or your family member became unemployed were you (or any dependents) eligible for coverage under any other group health plan (such as a plan sponsored by a later employer or a spouse's employer) or Medicare? If yes, please note the date you (or any dependents) became eligible for the other coverage.	☐	☐	☐
☐☐/☐☐/☐☐☐☐			

Fill in the information below that applies to you. * Denotes required information

Plan Sponsor Information: Please enter the following information about the employer, union, or joint board of trustees that sponsors the group health plan as completely as possible and attach any supporting documentation you have. Note: This information may be found on the COBRA notice you received.

*Name of Plan Sponsor

Best Person at Plan Sponsor to Contact: Mr. ☐ Mrs. ☐ Ms. ☐

Last First

*Street Address

*City State Zip code

*Phone number: Fax number:

Plan Sponsor's E-mail Address:

Plan Sponsor's Web site address:

Employer Information: If the plan sponsor is not the employer, please enter the following information about the employer. Yes ☐ No ☐ Unsure ☐

*Name of Employer

Best Person at Employer to Contact: Mr. ☐ Mrs. ☐ Ms. ☐

Last First

*Street Address

*City State Zip code

*Phone number: Fax number:

Employer's E-mail Address:

Employer's Web site address:

If you believe another entity such as a **parent company or a company that acquired your former employer** may be responsible for providing COBRA continuation coverage, please provide as much information about the company and the circumstances as possible. (Attach an additional sheet, if needed)

Parent Company or Purchaser's Name

Best Person at Parent Co. to Contact: Mr. Mrs. Ms.

Last First

Street Address

City State Zip code

Phone number: Fax number:

Parent Co./Purchaser's E-mail Address:

Parent Co./Purchaser's Web site address:

Insurance, HMO or Benefits Administrator Information: If applicable, please enter the following information about the insurance company, HMO, or benefits administrator that administers benefits for your group health plan as completely as possible and attach any supporting documentation you have.

*Name of Plan (ex. ABC Insurance Co PPO, Big Company Group Plan)

Name of Insurer, HMO or Benefits Administrator:

Best Person to Contact: Mr. Mrs. Ms.

Last First

Street Address

City State Zip code

Phone number:		Fax number:
Group Number of Insurance/Plan:	Applicant's Plan ID number:	

Other information : **IMPORTANT** Please provide what you were told about the reason(s) you were denied COBRA continuation coverage and/or the premium reduction as well as any other information you believe is important for the Department of Labor to know in order to evaluate your application. Since the Department's review cannot begin until we have a complete application, please attach copies of documentation that you believe would assist the Department in making a determination regarding your application. Such documentation could include copies of one or more of the following items:

- Your COBRA election notice,
- Your "Request for Treatment as an Assistance Eligible Individual" or other form used to request the premium reduction,
- Your insurance card,
- Payroll stubs showing deductions for health benefits,
- Any documents detailing the date and circumstances of the termination of the employee's employment, or
- Any documentation you were provided regarding the denial of the premium reduction.

Under penalty of perjury, I declare that I have examined this application, including any accompanying attachments, and to the best of my knowledge and belief, it is true, correct and complete. I hereby authorize the release of the information contained in and attached to this application, as well as any additional oral or written information that may be collected in connection with this review process, to any other parties to this review, including the health plan and the employee's former employer. I further authorize the individuals involved in processing this review to discuss with other individuals such information as they may deem necessary in resolving this review.

Signature: _____ Date: _____

Type or print name: _____

Privacy Act Notice

The Privacy Act of 1974 requires that when we ask you for information we tell you our legal right to ask for the information, why we are asking you for it, and how it will be used. We must also tell you what could happen if we do not receive it and whether your response is voluntary, required to obtain a benefit, or mandatory. Our legal right to ask for the information is section 3001(a)(5) of the American Recovery and Reinvestment Act of 2009 (ARRA). We are asking for this information to comply with the provisions of ARRA and to enable the Secretary of Labor to make a determination on your application for the Secretary's expedited review of the denial of your request for treatment as an assistance eligible individual. If you do not provide the requested information, you will not be eligible for such review. We do not sell the information that we collect. The personal information that you give us will be used only in connection with the Secretary's expedited review of the denial of your request for treatment as an assistance eligible individual.

We use contractors to perform various website and database functions. When we do, we make sure that the agreement language with the contractor ensures the security, confidentiality and integrity of any personal information to which the contractor may have access in the course of contract performance.

While online filing is secure, electronic mail is not secure. Therefore, we suggest that you don't send personal information to us by email. We will only send general information to you by email.

We may disclose the information you give us if authorized or required by Federal law, such as the Privacy Act. We may also disclose this information to the other parties to this review, including your health plan and, in many cases, to the employee's former employer, as well as to the courts as a part of the record on any appeal. You may have access to any of the information we collect about you. Also, if you provide false or fraudulent information, you may be subject to criminal prosecution. See section 1027, Title 18, U.S. Code (False statements and concealment of facts in relation to documents required by ERISA) and section 1001, Title 18, U.S. Code (Fraud and False Statements - Statements or entries generally). Other penalties may also apply.

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). 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.

Instructions for the Application to the U.S. Department of Labor for Expedited Review of Denial of COBRA Premium Reduction as Provided by the American Recovery and Reinvestment Act of 2009

*Please provide the required information where you see a *****. All other information is optional but will assist the Department in its review.*

Contact Information Please complete the fields, if filing by mail or fax, by entering one letter or number per box. Please print clearly as demonstrated.

*Name Mr. [X] Mrs. [ ] Ms. [ ]																								
Last												First										Middle Initial		
S	M	I	T	H								J	O	H	N									
*Street Address																								
1	2	3	4		M	A	P	L	E		L	A	N	E										
*City																	State			Zip code				
A	N	Y	T	O	W	N											S	T		9	8	7	6	5

Lines D1-D4 When adding information on your dependents, please remember that a separate application(s) must be completed for any family member whose information is not identical to the information you provide.

Please answer Questions 1-10 by placing an X in the appropriate box ([X]).

Question #1 Answer YES to this question if you were covered by the group health plan. If you were not enrolled but should have been, answer UNSURE and explain the circumstances in the other information section at the end of the application. If you acquired a new dependent (or dependents) by birth, adoption, or placement for adoption at any time after the date of the qualifying event and you made a timely request to special enroll the new dependent(s), answer YES to this question.

Question #2 Answer YES if the employee's job termination occurred from September 1, 2008 through December 31, 2009. Answer NO if the termination occurred before September 1, 2008 or after December 31, 2009.

Question #3 Answer YES if you have an ongoing health plan, if your former employer was acquired by another business that provides group health benefits, or if the employee's former employer was a "trade or business" under common control. The acquiring business or other employers in the control group may have to offer you COBRA continuation coverage. If these situations do not describe your health plan, answer NO to this question. If you answer NO, you may have no plan from which to obtain COBRA continuation coverage. If so, the premium reduction would not apply.

Question #4 For purposes of the premium reduction, COBRA qualifying events such as divorce, legal separation, entitlement to Medicare, a child ceasing to be a dependent child under the terms of the plan, or death of the employee are not terminations of employment.

Question #5 To be eligible for the COBRA premium reduction, the employee's job termination must have been involuntary. Whether a termination of employment is an involuntary termination of employment is determined based on all the relevant facts and circumstances. Examples of situations that may constitute an involuntary termination of employment are listed in Question 5. For help in determining if other situations are involuntary terminations, see the IRS guidance at www.irs.gov/pub/irs-drop/n-09-27.pdf. Check the appropriate box that describes your situation. If none of the examples address your termination, answer YES in Item 5f and describe the circumstances of your termination in the **Other Information** box at the end of the application. Also please note:

An employee and his or her dependents may not be eligible for COBRA continuation coverage if the employee was terminated from employment for gross misconduct.

Question #6 If you were employed by a private-sector employer, answer NO. If your benefits were provided by the Federal government, a State or local governmental plan, or a church plan, answer YES. If you answered YES to this question, the Department of Labor may not have jurisdiction to review your request for review. You should send an application for review to the Department of Health and Human Services. Instructions on how to submit such an application may be found at www.cms.hhs.gov/COBRAContinuationofCov.

Question #7 Answer based upon the number of employees you believe your employer had. We recognize that you may not have the information to confirm this response. Generally, Federal COBRA only applies to group health plans maintained by employers that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year, counting full- and part-time employees.

Please note: Although Federal COBRA rules do not apply to these small employers, the COBRA premium reduction applies to comparable continuation coverage that is provided pursuant to State law. If you answer NO to this Question indicating that your employer had fewer than 20 employees, your plan may be providing comparable State coverage. Contact the Department of Health and Human Services (HHS) at www.cms.hhs.gov/COBRAContinuationofCov to determine whether State law applies to your coverage and whether you can file an application with HHS for review.

Question #8 If you were offered COBRA continuation coverage in connection with your or your family member's job, select the answer that best addresses the status of your COBRA election. The COBRA election notice should be provided to qualified beneficiaries within 44 days of a qualifying event and should include information to help you understand COBRA coverage, including the name of the plan's COBRA administrator. If you received such a notice, answer YES. You must be given an election period of at least 60 days (starting on the later of the date the notice was sent to you or the date you would lose coverage) to choose whether or not to elect COBRA continuation coverage. Did you let your plan know that you elected COBRA continuation coverage? If so, answer YES. If you requested COBRA continuation coverage but were denied, your plan must provide a notice within 14 days after receiving your request and the notice must explain the reason for denying your request. Refer to this notice to answer the question and provide the reason in the Other Information section at the end of the application and attach a copy of the notice with your application.

Note that ARRA added a second election period for some individuals who experience an involuntary job termination from September 1, 2008 through February 17, 2009. If these individuals did not elect COBRA continuation coverage on their first opportunity, or elected COBRA continuation coverage but dropped it, they have a second opportunity to elect it.

Question #9 Please select the answers that best address your situation. Plans subject to the Federal COBRA provisions must send the General Notice to all qualified beneficiaries, not just covered employees, who experienced a qualifying event at any time from September 1, 2008 through December 31, 2009, regardless of the type of qualifying event, AND who either have not yet been provided an election notice or who were provided an election notice on or after February 17, 2009 that did not include the additional information required by ARRA. The General Notice must include information on the COBRA premium reduction. If you received this notice, answer YES. If you were denied the COBRA premium reduction, your plan may have provided you written notification of the reason for the denial, possibly on the form you used to request the premium reduction. If so, refer to that document to provide the reason in the Other Information section at the end of the application and attach a copy of the document with your application. If you have received no response to your request, you should answer "Unsure."

Question #10 Answer YES if you are *eligible for coverage* under another group health plan or Medicare benefits. If you answer YES to this Question, you are not eligible for the premium reduction on the first date of eligibility for the other coverage. Note: If you are eligible for the premium reduction, you are required to notify the plan when you become eligible for Medicare or other group health coverage. Failure to do so may subject you to a tax penalty of 110 percent of the amount of any premium reduction.

Information on your plan sponsor/employer, insurance company, and/or plan administrator Refer to the COBRA notice you received to find the information to use for this application. Attach a copy of the COBRA notice to your application.

Other Information Please provide what you were told about the reason(s) you were denied COBRA continuation coverage and/or the premium reduction as well as any other information you believe is important for the Department of Labor to know in order to evaluate your application.

Attachments Since the Department's review cannot begin until we have a complete application, please attach copies of documentation that you believe would assist the Department in making a determination regarding your application. Such documentation could include copies of one or more of the following items, if relevant and applicable: your COBRA election notice, your Request for Treatment as an Assistance Eligible Individual or other form used to request the premium reduction, your insurance card, payroll stubs showing deductions for health benefits, any documents detailing the date and circumstances of the termination of the employee's employment, or any documentation you were provided regarding the denial of the premium reduction.

If you submit attachments for this application after submitting the application or if you fax or mail attachments for an online application, be sure to clearly print your name and phone number on the first page of any document you send. If you know your control identification number please print that as well.