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

President Biden signed 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 qualify 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 (this means you must complete the Fund's "COBRA Election Form", if you have not already done so);
- **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.

◊ Each family member who is applying for ARP premium assistance must sign the "Blue Form": Request for Treatment As An Assistance Eligible Individual (either as the Employee or Dependent). A parent or guardian should sign the form for a minor child. *Domestic Partners are not eligible for premium assistance.*

◊ If you elect COBRA coverage with premium assistance, and then become eligible for Medicare or 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), you MUST notify the Fund in writing by using the "Yellow Form". 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 Fund is due to reasonable cause and not due to willful neglect.

◊ Employers that don't satisfy COBRA 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 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 coverage with or without the premium assistance.

For general information on the Fund's COBRA coverage, specific information about ARP premium assistance, or to notify the Fund of your ineligibility to receive premium assistance, you can contact the Administrative Office of the Fund at: **Santa Monica UNITE HERE Health Benefit Trust Fund, c/o Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, (866) 345-5189. For one-on-one assistance, call the COBRA Team at (213) 456-2012.**

For more information regarding ARP premium assistance and eligibility questions, visit https://www.dol.gov/cobra-subsidy or contact the Department of Labor at askebsa.dol.gov or 1-866-444-EBSA (3272)

* 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.

**To apply for ARP Premium Assistance, complete this form and return it to the Administrative Office. If you do not return the completed form within 60 days of receipt, you may be unable to receive the premium assistance.**

| | | |
|---|---|---|
| **Santa Monica UNITE HERE Health Benefit Trust Fund**<br>c/o Benefit Programs Administration | **REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**<br>**(Fill out this "BLUE FORM" for Free COBRA)** | 1200 Wilshire Blvd.,<br>Fifth Floor<br>Los Angeles, CA 91746<br>(866) 345-5189 |

## PERSONAL INFORMATION (List any dependents on the back of this form)

**Name:** _____

**Mailing Address:** _____

**City:** _____ **State:** ____ **Zip Code:** _____

**Telephone number:**

**(_____) _____-_____**

**Date of Birth:** _____/_____/_____

**SSN:** _____

## To qualify, you must be able to check 'Yes' for all statements.

| | |
|---|---|
| 1. The qualifying event was a loss of employment that was involuntary or a reduction in hours. | ☐ Yes ☐ No |
| 2. I elected (or am electing) COBRA coverage. (If you are not yet enrolled in COBRA, you must complete the Fund's "COBRA Election Form.") | ☐ Yes ☐ No |
| 3. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming premium assistance). | ☐ Yes ☐ No |
| 4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance). | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

**FOR FUND USE ONLY**

This request is: ☐ Approved ☐ Denied Specify reason in #4 below and return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

| | |
|---|---|
| 1. Loss of employment was voluntary. | ☐ |
| 2. Individual did not experience a reduction in hours. | ☐ |
| 3. Individual did not elect COBRA coverage. | ☐ |
| 4. Other (please explain) | ☐ |

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Fund:

→ _____ Date → _____

Type or print name → _____ → Telephone number: (866) 345-5189

**Need one-on-one help filling out this form? Call the COBRA team at (213) 456-2012 to make an appointment. General questions about COBRA? Call the Fund at (866) 345-5189.**

For Further Assistance, you may also contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272, or online at https://www.askebsa.dol.gov/WebIntake.

**DEPENDENT INFORMATION** (Must fill out for every covered dependent applying for Free COBRA. Parent or guardian should sign for minor children. Domestic Partners are not eligible for ARP premium assistance.)

1.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

2.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

3.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

**DEPENDENT INFORMATION** (Must fill out for every covered dependent. Parent or guardian should sign for minor children. Domestic Partners are not eligible for ARP premium assistance.)

4.

First Name: _____ Last Name: _____

SSN : _____ Date of Birth:_____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → ____/____/_____

Type or print name → _____ Relationship to employee → _____

5.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → ____/____/_____

Type or print name → _____ Relationship to employee → _____

6.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → ____/____/_____

Type or print name → _____ Relationship to employee → _____

**DEPENDENT INFORMATION** (Must fill out for every covered dependent. Parent or guardian should sign for minor children. Domestic Partners are not eligible for ARP premium assistance.)

7.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____/_____/_____

Type or print name → _____ Relationship to employee → _____

8.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth: _____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

9.

First Name: _____ Last Name: _____

SSN: _____ Date of Birth:_____/_____/_____

**To qualify, you must be able to check "Yes" for all statements.**

| | |
|---|---|
| 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 |
| 4. The qualifying event was a reduction in hours or an involuntary termination of employment. | ☐ Yes ☐ No |

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____