Use this "Yellow Form" to notify the Fund that you are eligible for other group health plan coverage or Medicare and therefore NOT ELIGIBLE for premium assistance (Free COBRA) under the ARP.

DO NOT FILL OUT THIS FORM UNLESS YOU CALL THE FUND FIRST: (866) 345-5189

Santa Monica UNITE HERE
Health Benefit Trust Fund
c/o Benefit Programs
Administration

Participant Notification of Ineligibility for ARP Premium Assistance

(For assistance completing this form, call the COBRA Team at: 213-456-2012.)

1200 Wilshire Blvd.,
Fifth Floor
Los Angeles, CA 91746
(866) 345-5189

PERSONAL INFORMATION

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: (_____) _____

Date of Birth: _____/_____/_____

SSN: _____

PREMIUM ASSISTANCE INELIGIBILITY INFORMATION

I. ELIGIBILITY FOR OTHER GROUP HEALTH PLAN COVERAGE. *Complete this Section only if it applies to you or a Dependent.*

1. I am eligible for coverage under another group health plan ("GHP"): ☐ Yes ☐ No
2. Insert date you became (or will become) eligible for coverage under the other GHP: ____/____/_____
   ***Eligibility for coverage does not include any time spent in a waiting period. Thus, you become eligible for other GHP coverage on the earliest date you could start your other coverage even if you decline the other coverage.*
3. If your Dependents are also eligible for other GHP coverage, you must list their names here:

Names of Dependents Eligible for GHP Coverage	Date Eligible for GHP Coverage	Names of Dependents Eligible for GHP Coverage	Date Eligible for GHP Coverage
1.	/ /	6.	/ /
2.	/ /	7.	/ /
3.	/ /	8.	/ /
4.	/ /	9.	/ /
5.	/ /	10.	/ /

II. ELIGIBILITY FOR MEDICARE. *Complete this Section only if it applies to you or a Dependent.*

1. I am (or will become) eligible for Medicare: ☐ Yes ☐ No
2. Insert date you became (or will become) eligible for Medicare: _____/_____/_____
3. If any Dependents are (or will become) eligible for Medicare, you must list their names here:

Names of Dependents Eligible for Medicare	Date Eligible for Medicare
1.	/ /
2.	/ /

Form Continues on Back

CONTINUATION OF COBRA AFTER ARP PREMIUM ASSISTANCE (FREE COBRA) ENDS

This form notifies the Fund that you and/or your Dependents are no longer eligible for ARP Premium Assistance (free COBRA). However, if you do not enroll in the other GHP coverage or Medicare and are still within your maximum COBRA coverage period, you may be able to continue your COBRA coverage by making the full monthly COBRA payments (shown on the Fund's COBRA Rate Sheet). If you choose to continue COBRA for yourself and/or any family member(s), and you do not timely pay COBRA premiums to the Fund, COBRA coverage will end early.

Check the box that applies to you (check only one box):

☐ I would like to terminate COBRA coverage for myself and all of my Dependents when our ARP Premium Assistance (Free COBRA) ends.

☐ I would like to terminate COBRA coverage for all of my family members (including myself), **except the family members listed in the box below who will continue their COBRA coverage** (*note: to continue COBRA coverage for yourself, your name must be listed in the box below)*. The family members who are continuing COBRA coverage (and are listed in the box below), did not (or will not) enroll in the other GHP coverage or Medicare and understand that we/they will have to pay the full cost of COBRA after ARP Premium Assistance ends.

Continue COBRA Coverage After ARP Premium Assistance Ends For the Listed Individuals	Date of Birth	Continue COBRA Coverage After ARP Premium Assistance Ends For the Listed Individuals	Date of Birth
1.	/ /	5.	/ /
2.	/ /	6.	/ /
3.	/ /	7.	/ /
4.	/ /	8	/ /

IMPORTANT

If you fail to notify the Fund when you become eligible for other group health plan coverage or Medicare AND continue to receive COBRA premium assistance, you may be subject to a penalty of $250 dollars (or if the failure is fraudulent, the greater of $250 or 110% of the amount 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.

Eligibility for other coverage is determined without regard to whether you take or decline the other coverage. This means that you are considered eligible for other coverage, even if you decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period (i.e., your ARP Premium Assistance (free COBRA) will end on the earliest date you could start your other coverage, even if you decline the other coverage).

PLEASE SIGN BELOW

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 → _____

FOR FUND INTERNAL USE ONLY

COMMENTS: