

## State Health Benefit Plan (SHBP)

### APPLICATION FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL DUE TO INVOLUNTARY TERMINATION OF EMPLOYMENT 9/1/08 – 12/31/09

This official statement by you, your dependents and your former employer is required to prove that you and any dependents eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) are allowed to receive COBRA coverage by paying only 35 percent of the COBRA premium. **This is NOT an SHBP COBRA Enrollment Form.**

1. Complete the parts of this form marked "Employee"
2. Have each Dependent complete the part of this form marked "Dependents"
3. Have your Human Resources Manager complete the part of the form marked "HR Manager"
4. Return the completed form with your SHBP COBRA Enrollment Form (if you are not already on COBRA) OR send this form separately by addressing it: State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990, ATTN: COBRA Premium Reduction
5. Keep a copy of the signed form

**Note:** You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

#### EMPLOYEE: PERSONAL INFORMATION

Employee First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Street: \_\_\_\_\_ Apt. # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
**(List all dependents on the reverse side of this form.)**

#### EMPLOYEE: (To qualify, you must be able to check 'Yes' for all statements.)\*

1. The loss of employment was involuntary, because it was the direct result of an action taken by my employer while I was ready, able and willing to keep working. **	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT able to enroll right away in another group medical plan (or I was not able to enroll right away in another group medical plan during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

**\*If you checked No for statement 3, you may still be eligible. See below for more information.**

\*\*Examples of involuntary loss of employment include being fired, being laid off, nonrenewal of contract, reduction in hours to zero, and elimination of your job for the convenience of your employer. The loss of employment can be involuntary even if you resigned or retired, if the reason you resigned or retired was because you were told that otherwise your employment would be terminated for one of the above reasons. In addition, if you resigned or retired because of an important adverse change in your employment caused by your employer, such as a furlough, significant reduction in your hours or pay, or mandatory relocation, your resignation or retirement is considered an involuntary loss of employment.

#### ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage OR you elected but subsequently discontinued COBRA, this Application for Treatment as Assistance Eligible Individual came in a packet with a new SHBP COBRA Enrollment Form and an explanation that you may have a right to elect COBRA again. If you believe you should have received this additional notice and Form but have not, contact State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990, phone 404-656-6322 or 800-610-1863.

**DEPENDENT INFORMATION** (Parent or guardian should sign for minor children.)

A. _____			
Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
1. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT able to enroll right away in another group medical plan.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I make an election to exercise my right to the COBRA/ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.</p> <p>Signature: _____ Date: _____</p> <p>Type or print name: _____ Relationship to employee: _____</p>			

B. _____			
Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
1. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT able to enroll right away in another group medical plan.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I make an election to exercise my right to the COBRA/ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.</p> <p>Signature: _____ Date: _____</p> <p>Type or print name: _____ Relationship to employee: _____</p>			

C. _____			
Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
1. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT able to enroll right away in another group medical plan.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I make an election to exercise my right to the COBRA/ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.</p> <p>Signature: _____ Date: _____</p> <p>Type or print name: _____ Relationship to employee: _____</p>			

**HR Manager at Payroll Location (You must check an answer for each question.)**

1. The employee's employment was involuntarily terminated for one of the following reason: Layoff (with or without recall rights) Reduction in hours to zero Termination for cause (other than for "gross misconduct") Termination for convenience Elimination of the job Non-renewal of contract by the employer	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The <b>employee resigned or retired after getting a notification of his or her upcoming termination of employment as described in 1 above.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The employee resigned or retired after the employer made a significant, adverse change to the employment relationship, such as mandatory relocation, reduction in hours, reduction in pay, furlough.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I checked "No" to 1, 2, and 3 above, but for the following reason, the termination of employment was "involuntary." (Describe reason) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I checked "No" to 1-4 above, and the termination of employment was voluntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Payroll Location #: \_\_\_\_\_ Payroll Location Name: \_\_\_\_\_

Signature of Payroll Location HR Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Type or print name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**FOR SHBP USE ONLY**

This application is:

- Approved for all   
  Approved for some/denied for others (see #3 below)   
 Required Monthly Premium \$ \_\_\_\_\_  
 Denied for all   
 Specify reason below and then return a copy of this form to the applicant

**REASON FOR DENIAL OF COBRA PREMIUM REDUCTION REQUESTED (TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL)**

1. Loss of employment was voluntary.  Yes  No  
 2. The involuntary loss of employment did not occur between September 1, 2008 and December 31, 2009.  Yes  No  
 3. Other (please explain).  Yes  No

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Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Employee Note: Any denial may be appealed to the Department of Health and Human Services**