



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



President Biden signed H.R. 1319, 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 be eligible 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;
- **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.
- ◇ If you elect COBRA continuation coverage with premium assistance, and then become eligible for 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), or if you become eligible for Medicare, you **MUST** notify the plan in writing. 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 plan is due to reasonable cause and not due to willful neglect.
- ◇ Employers that don’t satisfy COBRA continuation 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 continuation 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 continuation coverage with or without the premium assistance.

For general information on your plan’s COBRA continuation coverage, visit [MyTeamCare.org](https://www.teamcare.org), call 800-TEAMCARE (832-6227), or write Self-Payments Department, TeamCare, PO Box 5108, Des Plaines IL 60017-5108

For specific information on your plan’s administration of the ARP premium assistance or to notify the plan of your ineligibility to receive premium assistance, call: 800-TEAMCARE (832-6227) or contact: Self-Payments Department, TeamCare, PO Box 5108, Des Plaines IL 60017-5108 or fax: 847-868-3178, Attn. Self-Payments Department. 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 reimbursement 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.



(Page 1: Request for Treatment as an Assistance Eligible Individual)

To apply for COBRA Premium Assistance, complete this form and return it to TeamCare at:

- Mail: Self-Payments Dept, TeamCare, PO Box 5108, Des Plaines IL 60017-5108; or
• Email: AEIRequests@centralstatesfunds.org; or
• Fax: 847-868-3178 Attn. Self-Payments Department

If you are already enrolled in COBRA, you may send this form in separately. If you have not yet elected COBRA continuation coverage, you may send this form along with your Election Form. If you do not complete this form and return it within 60 days of receipt, you may be unable to receive the premium assistance.

Header section with TEAMCARE logo, REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL title, and TeamCare contact information (PO Box 5108, Des Plaines IL 60017-5108).

PERSONAL INFORMATION section containing fields for Name and mailing address of employee, Telephone number, E-mail address, and Unique Member Identification Number (UMI) or Social Security Number.

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

Qualification statements section with four numbered items and Yes/No checkboxes: 1. The qualifying event was a loss of employment... 2. I elected (or am electing) COBRA continuation coverage... 3. I am NOT eligible for other group health plan coverage... 4. I am NOT eligible for Medicare...

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 _____
PRINT NAME: _____ RELATIONSHIP TO EMPLOYEE _____

FOR TEAMCARE 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 PLAN ADMINISTRATOR: _____ DATE _____
PRINT NAME _____ TELEPHONE NUMBER 800-832-6227 E-MAIL ADDRESS _____

For further assistance, you may 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

(Parent or guardian should sign for minor children.)

DEPENDENT NAME: _____ **SOCIAL SECURITY #:** _____

DATE OF BIRTH: _____ **RELATIONSHIP TO EMPLOYEE:** _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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** _____

PRINT NAME: _____ **RELATIONSHIP TO EMPLOYEE:** _____

DEPENDENT NAME: _____ **SOCIAL SECURITY #:** _____

DATE OF BIRTH: _____ **RELATIONSHIP TO EMPLOYEE:** _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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** _____

PRINT NAME: _____ **RELATIONSHIP TO EMPLOYEE:** _____

DEPENDENT NAME: _____ **SOCIAL SECURITY #:** _____

DATE OF BIRTH: _____ **RELATIONSHIP TO EMPLOYEE:** _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the 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** _____

PRINT NAME: _____ **RELATIONSHIP TO EMPLOYEE:** _____



Use this form to notify TeamCare that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under the ARP.



PARTICIPANT NOTIFICATION

TeamCare
PO Box 5108
Des Plaines IL
60017-5108

PERSONAL INFORMATION

Form with fields for Name and mailing address, Telephone number, E-mail address (optional), and Unique Member Identification Number (UMI) or Social Security Number.

PREMIUM ASSISTANCE INELIGIBILITY INFORMATION – Check one

Form with two rows for eligibility information, each with a checkbox and a date field.

IMPORTANT

If you fail to notify your plan 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).

Eligibility for other coverage is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

SIGNATURE: _____ DATE _____

PRINT NAME: _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

Two horizontal lines for listing dependent names.