Oregon Continuation Coverage
American Recovery and Reinvestment Act of 2009
Premium Reduction Request Form

To apply for ARRA Premium Reduction, complete this form and return it to your employer along with your Enrollment Application Form reflecting your Oregon Continuation election.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number
	E-mail address (optional)

To qualify, none of your answers below can be "No".

1. The loss of employment was involuntary.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after Sept. 1, 2008 and on or before May 31, 2010.	☐ Yes ☐ No
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point between September 1, 2008 and May 31, 2010 AND the loss of employment occurred on or after March 2, 2010	☐ Yes ☐ No ☐ N/A
4. I elected (or am electing) continuation coverage.	☐ Yes ☐ No
5. 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 a reduced premium).	☐ Yes ☐ No
6. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	☐ Yes ☐ No

I make an election to exercise my right to the 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.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Oregon Continuation Coverage
American Recovery and Reinvestment Act of 2009
Premium Reduction Request Form

FOR EMPLOYER USE ONLY

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)
Specify reason below and then 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. The involuntary loss did not occur between Sept. 1, 2008 and May 31, 2010.	☐
3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010 or after May 31, 2010).	☐
4. Individual did not elect continuation coverage.	☐
5. Other (please explain)	☐

Group Name: → _____ Group Number: → _____

Date of reduction of hours (if any) → _____

Date of involuntary termination of employment (Termination Date): → _____

Attestation

I attest that the above named employee has (1) experienced an involuntary termination of employment as of the Termination Date listed above, or (2) experienced a reduction of hours at some point between September 1, 2008 and May 31, 2010, followed by an involuntary termination of employment as of the Termination Date listed above. I acknowledge that if ODS is sanctioned for noncompliance in connection with this attestation, the above named group will assume full responsibility and will indemnify and hold ODS harmless from and against any such sanction, liability, damages or other loss.

Signature of party responsible for continuation coverage administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

If approved for ARRA Premium Reduction remit form to ODS with the subscriber's completed Enrollment Application Form reflecting your Oregon Continuation election.

Oregon Continuation Coverage
American Recovery and Reinvestment Act of 2009
Premium Reduction Request Form

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

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) Oregon 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

I make an election to exercise my right to the 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.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) Oregon 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

I make an election to exercise my right to the 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.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) Oregon 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

I make an election to exercise my right to the 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.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____