Letter E, Additional Info Request to Plan Administrator

(Insert Date-system generated?)

Plan Administrator
Employer/Company
Plan Name
Plan Street Address
Plan City, State, Zip Code
Re: Application for Expedited Review of Denial of COBRA Premium Reduction
Applicant's name: [First Name] [Last Name]
Employee name: [First Name] [Last Name] Record number

Dear Plan Administrator:

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium assistance for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. The premium assistance is also available for continuation coverage under certain State laws. For coverage periods beginning on or after February 17, 2009, assistance eligible individuals pay only 35% of their continuation coverage premiums to the plan for the first nine months. The remaining 65% is reimbursed to the plan, employer, or health insurance issuer through a payroll tax credit.

To be eligible for assistance, an individual must meet ALL of the following requirements:

- Be eligible for continuation coverage under COBRA or a State law that provides comparable continuation coverage (for example, so-called "mini-COBRA" laws) at any time during the period beginning September 1, 2008 and ending December 31, 2009;
- Elect continuation coverage (when first offered or during the additional election period); and
- Have a qualifying event for the continuation coverage that is the employee's involuntary termination during the period beginning September 1, 2008 and ending December 31, 2009.

The applicant (person requesting review of a denial of premium assistance) may either be the former employee or a member of the employee's family who is eligible for COBRA continuation coverage or the COBRA premium assistance through an employment-based health plan. The employee and his/her family members may each elect to continue health coverage under COBRA, request the premium assistance, and request a review of a denial of premium assistance.

We have received an application for expedited review from the individual named above who claims to have been denied premium reduction in connection with COBRA continuation coverage under your plan. In order to make a determination regarding this person's eligibility for COBRA continuation coverage and the ARRA COBRA Premium Reduction, we need information from you regarding the individual's coverage under the plan and the circumstances

of the individual's job loss. The statute requires use to make a determination within 15 business days of receipt of the individual's request; therefore, we ask that you complete the information below and return it to us within 2 business days. *If we do not receive this information within that time period, we may have to make our determination solely on the basis of the information provided by the individual.*

Please complete the attached form and fax it back along with any supporting documentation to XXX-XXX-XXXX by the close of next business day. If you have any questions about the information you can contact a representative at XXX-XXX-XXXX.

Sincerely,

Cobra Appeals Processing Unit

Attachment

Plan Administrator Information Sheet

OMB Control Number 1210-XXXX
Expiration Date: XX/XX/XXXX

Applicant's name: [First Name] [Last Name])
Employee name: [First Name] [Last Name]
Record number

Please indicate whether the applicant was denied COBRA continuation coverage or the ARRA COBRA Premium Reduction and if denied, check the reason for the denial below:

 Not Denied, the applicant has been provided with or will be provided with COBRA continuation coverage and the Premium Reduction.

Please enter the date the applicant's request was approved: _____/_____/_____

 Denied because the employee's job termination was voluntary. Please enter any pertinent details regarding the circumstances of the employee's termination in the comment section below.

 Denied because the employee's job loss did not occur between September 1, 2008 through December 31, 2009.

Please enter the date of the covered employee's termination: _____/_____/_____

 Denied because the applicant's loss of coverage did not occur between September 1, 2008 through December 31, 2009.

Please enter the date of the applicant's loss of coverage: _____/_____/_____

 Denied because the applicant was not covered by the group health plan on the day before the qualifying event, and was not a new dependent (or dependents) by birth, adoption, or placement for adoption.

 Denied because the applicant did not elect COBRA continuation coverage (either at the first opportunity or under the Extended Election period).

 Denied because the employee was dismissed for gross misconduct; therefore, the applicant was not offered COBRA continuation coverage.

 Denied because the employer is exempt from COBRA under the small employer exemption.

The rules regarding whether an employer is exempt from COBRA under the small-employer exception can be complex. Generally, COBRA only applies to group health plans maintained by employers that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

If exempt under the small employer exception, is the plan fully insured and subject to state continuation coverage? ☐ Yes ☐ No ☐ Unsure

☐ Denied because the employer no longer sponsors a group health plan. Please check the box or enter the date as appropriate:

☐ The employer never sponsored a group health plan.
The employer sponsored a health plan, but it was terminated effective ____/____/_____

If you no longer sponsor a group health plan, is there another entity* that may be liable to provide COBRA continuation coverage to the participants and beneficiaries?
☐ Yes ☐ No ☐ Unsure If yes, please enter the name, address and contact information for that entity in the comment section below as well as a brief description of the circumstances that you believe makes them liable to provide COBRA continuation coverage.

*Please note: under special rules, if your company was acquired by another business that provides group health benefits, the acquiring business may have successor liability and a duty to offer COBRA continuation coverage to participants and beneficiaries. Additionally, all of COBRA's requirements apply to employers on a "controlled group" basis as defined in the Internal Revenue Code. These rules may require employers in a "parent-subsidiary" or "brother-sister" relationship as measured by an ownership test to provide COBRA benefits. If you acquired or were acquired by another business, or your business is part of a control group, you may want contact EBSA toll free at 1-866-444-3272 to speak to a Benefits Advisor for assistance in determining whether you or another entity may need to provide COBRA continuation coverage.

☐ Denied for Other reason(s), please explain:

_____
_____
_____
_____
_____
_____
_____

Under penalty of perjury, I declare that the information completed above and any accompanying attachments are true, correct and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Type or print name: _____

Address, if different from above: _____

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain benefit (*see* section 3001(a)(5) of the American Recovery and Reinvestment Act, P.L. 111-5). Please send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 and reference the OMB Control Number. **Note**: Please do not return the completed application to this address.