

WPS Request for Information
FAX RESPONSES TO (608) 243-6138

Name of Employer _____
Group Number _____
Contact Person _____
Address _____
City / State / Zip _____
Telephone Number _____

1. Under state law, as the employer you must continue to notify all terminated employees of the availability of the subsidy when notifying them of their continuation rights. As part of this process, employees will be required to attest to meeting the definition of “involuntarily terminated” and indicate whether or not they would like to elect Wisconsin continuation under your health policy. Those election forms and attestations will then be sent directly to you, the employer, for your records. Upon receipt, you must forward those forms to WPS in order to add that employee to your policy and allow WPS to provide the premium subsidy to your former employee and offset that subsidy on our payroll taxes.

2. On the enclosed “Request for Information – Involuntarily Terminated Insureds NOT Currently Covered” spreadsheet, please provide the name, last known billing address, telephone number, social security number and the date of termination for **any employee that you have involuntarily terminated between September 1, 2008 and December 31, 2009 who has not yet elected Wisconsin continuation on your policy.** By providing this information to WPS, you are certifying that the individuals meet the federal definition of “involuntarily terminated.” Please fax this form, the employee election form, employee attestation and the completed Request for Information spreadsheet to (608) 243-6138.

Are you an Employer subject to COBRA? **YES** _____ **NO** _____

If your answer to this question is “yes,” please discontinue filling out this form. Employers subject to COBRA are required by federal law to administer the subsidy and notify potential AEIs of their right to the subsidy.

By signing this form I agree that I am **an employer NOT subject to COBRA, and I AM an employer subject to Wisconsin continuation.** By signing this form and completing attached Involuntarily Terminated Insureds spreadsheet, I agree that the employees identified meet the definition of “involuntarily terminated” as defined by the American Recovery and Reinvestment Act of 2009. I further understand that only the employer can determine eligibility for the subsidy under the Act.

Signature of Small Employer _____ Date _____

* For more information on the federal definition of “involuntarily terminated” please refer to the Internal Revenue Service’s Notice 2009-27, Q&A 1– 9 at <http://www.irs.gov/pub/irs-drop/n-09-27.pdf>

To apply for ARRA Premium Reduction AND/OR to elect Wisconsin Continuation coverage and treatment as an AEI, please complete this form and return it to:

[Enter Employer's Name, Address, telephone number and contact person]

You may also want to read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA."

[Employer Name]

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)

Please fill out this section only if you are currently covered under Wisconsin Continuation.

1. The loss of employment was involuntary AND occurred at some point on or after September 1, 2008 and before May 19, 2009 AND I am currently covered under Wisconsin Continuation AND I am using this form to apply for treatment as an assistance eligible individual.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. By checking "yes" in this box I am certifying that I am NOT eligible for other group health plan coverage during any period for which I am claiming a reduced premium. I am NOT eligible for Medicare (nor was I eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please fill out this section only if you wish to <u>elect</u> Wisconsin Continuation coverage and wish to be treated as an assistance eligible individual.	
1. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009 AND I am using this form to elect Wisconsin Continuation coverage AND I am using this form to apply for treatment as an assistance eligible individual.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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). I am NOT eligible for Medicare (nor was I eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

I wish to elect individual coverage for myself Yes No

I wish to elect family coverage for myself and spouse and/or dependents Yes No

Based on the answers I have supplied above and by signing this form I am either making an election for Wisconsin continuation and treatment as an assistance eligible individual, or requesting treatment as an assistance eligible individual for continuation coverage I have already elected. 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 → _____

FOR EMPLOYER USE ONLY

This application is: Approved Denied Approved for some/denied for others (explain in #3 below)
Specify reason below and then return a copy of this form to the applicant and WPS.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary and individual does not meet the definition of an AEI. <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009 and the individual is not currently covered under Wisconsin continuation. <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
3. Other (please explain)	<input type="checkbox"/>
	<input type="checkbox"/>

Signature of party responsible for continuation coverage administration for the plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA.

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an Assistance Eligible Individual and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- 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 successor employer or a spouse’s employer.*

◆ IMPORTANT ◆

- ◇ **If, after you elect state continuation coverage and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify your prior employer. If you do not, you may be subject to a tax penalty.**
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

www.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov
