

Customer Name:
Address:
Customer Number:
Employer:

This notice contains important information about your right to continue your health care coverage under Wisconsin Statute § 632.897.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a qualifying event under state continuation that resulted in a loss of coverage that occurred during the period that begins with September 1, 2008 and February 17, 2009 and are currently covered under Wisconsin Continuation may be eligible for the temporary premium reduction for up to nine months. Additionally, individuals who are receiving this election notice in connection with a qualifying event that resulted in the loss of coverage that occurs from September 1, 2008 to December 31, 2009 and who have not yet elected Wisconsin Continuation coverage may also be eligible for the temporary premium reduction for up to nine months. If your state continuation coverage relates to an involuntary loss of employment from September 1, 2008 through May 19, 2009, and you were eligible for but did not elect, state continuation coverage OR you elected but subsequently discontinued state continuation, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form from your former employer which you MUST complete and return. If you believe you should have received this additional notice but have not, contact your employer.

To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the Continuation Coverage Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form to your employer.**

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to the address listed on the form.

Eligible employees are entitled to elect continuation coverage for themselves and their eligible dependents which will continue group health care coverage under your former employer's policy for up to 18 months.

WPS does not permit Assistance Eligible Individuals ("AEI's") to elect to enroll in coverage that is different coverage in which the individual was enrolled at the time the qualifying event occurred. You cannot change coverage options for your continuation coverage to something different than what you had on the last day of employment.

Your cost for continuation coverage will be 35% of the total cost of your normal premium. After submitting your election notice to your employer, your employer will send you a billing statement notifying you of what this amount will be.

If it is determined that you are an AEI and eligible for assistance as of March 1, 2009 and you have already paid the full premium to your former employer for any month in which you were assistance eligible, WPS will work with your former employer to determine the amount of your overpayment and you will be issued a refund check.

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:

Employer Name:
Address:
Telephone:
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."

Enter Employer Name

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Enter Employer Address

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, you must be able to check "Yes" for all statements

1. The loss of employment was involuntary. Please check one box below to designate the circumstances of the loss of employment. <input type="checkbox"/> Discharge <input type="checkbox"/> Permanent Layoff <input type="checkbox"/> Temporary Layoff <input type="checkbox"/> Other	<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. Please provide the date of termination: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I elected (or am electing) COBRA continuation coverage. *	<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

ADDITIONAL ELECTION PERIOD

If your state continuation coverage relates to an involuntary loss of employment from September 1, 2008 through May 19, 2009, and you were eligible for but did not elect, state continuation coverage OR you elected but subsequently discontinued state continuation, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form from your former employer which you MUST complete and return. If you believe you should have received this additional notice but have not, contact your employer.

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 → _____

FOR EMPLOYER USE ONLY

This application is: Approved Denied (explain in #4 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.	<input type="checkbox"/>
3. Individual did not elect continuation coverage	<input type="checkbox"/>

4. Other (please explain).



Signature of party responsible for continuation coverage administration for the plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

This form is designed for issuers to distribute to qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the issuer if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your issuer that you are eligible for other group health plan coverage or Medicare.

Plan Name

Participant Notification

Plan Mailing Address

PERSONAL INFORMATION

Name and mailing address

Telephone number

E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan.
If any dependents are also eligible, include their names below.

Insert date you became eligible _____

I am eligible for Medicare.

Insert date you became eligible _____

IMPORTANT

If you fail to notify your issuer of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced continuation coverage premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility 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 → _____

Type or 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:

Summary of the 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 premiums for periods of COBRA or state continuation coverage beginning on or after February 17, 2009, and can last up to 9 months. Please note, you may be eligible for Wisconsin continuation coverage but not qualify as an assistance eligible individual due to ARRA qualifying requirements for premium reduction.

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 continuation and while you are paying the reduced premium, you become eligible for other group health plan coverage you MUST notify the plan in writing. 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.

For general information regarding continuation coverage, information related to your plan’s administration of the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, please contact your former employer.

If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

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

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.