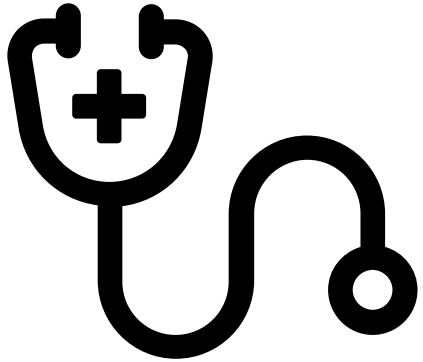
FREE HEALTH INSURANCE!

WE WON IT—
LET'S GO GET IT!

How to enroll in FREE COBRA



Philly
UNITEHERE!
Local 274

TAKE BACK OUR HEALTH

Know your rights!

UNITE HERE workers fought hard to win FREE healthcare (COBRA) for 6 months, paid for by the U.S. government.

We're going to look at government forms that can be confusing. But you got this. We're right here with you.

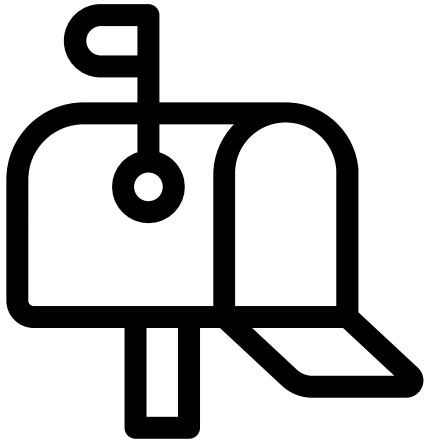
REMEMBER: if you're eligible, you have a RIGHT to this FREE HEALTHCARE

What is COBRA?

COBRA is a federal law that lets you continue your health insurance after you lose your job.

It’s usually expensive, but we won free COBRA April 1 through September 30 for millions of workers!

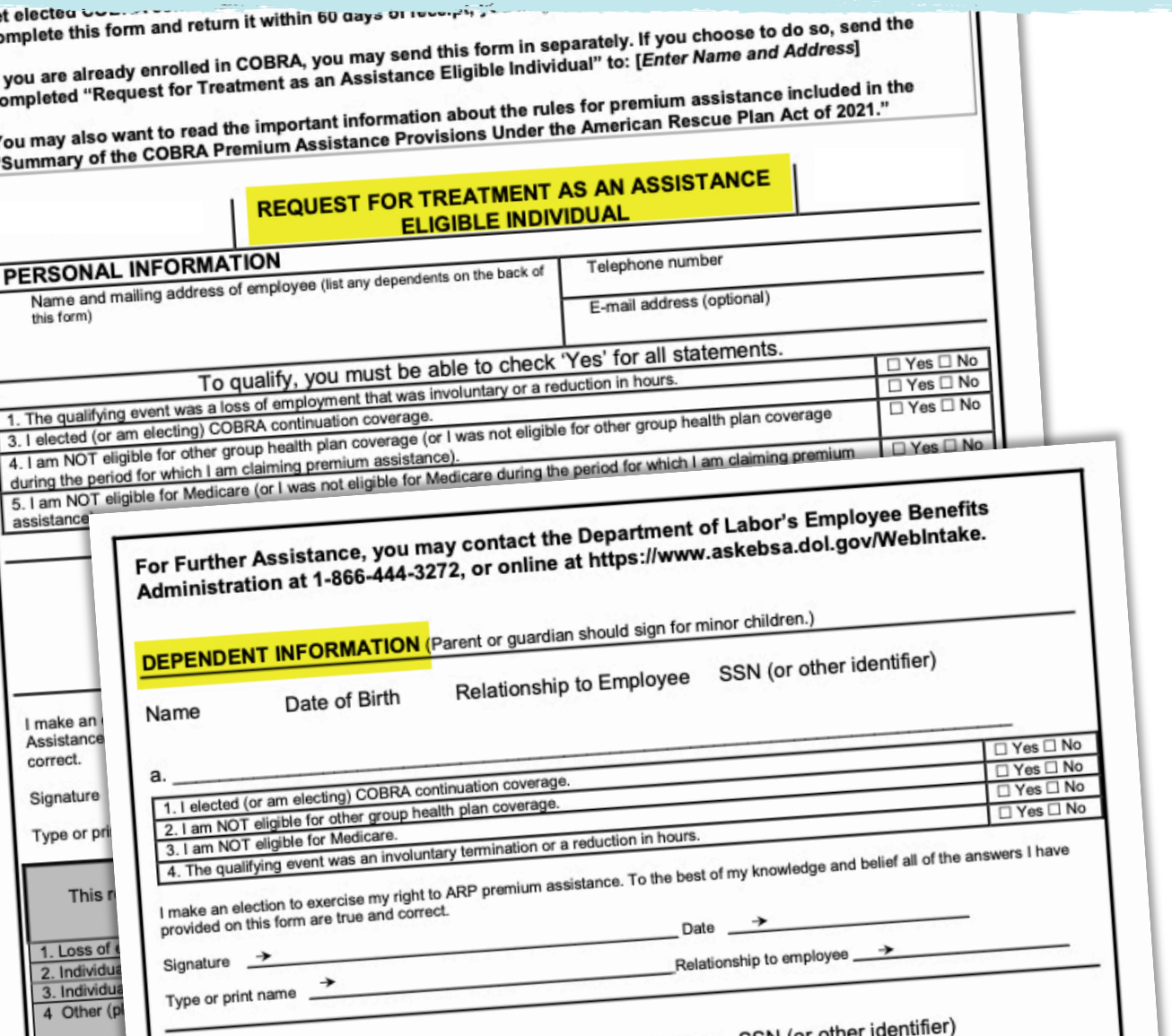
STEP 1: Check your mail!



Look for a mailing from the Local 274 Health & Welfare Fund.

If you don't see the packet by Monday, June 7, call 215-751-9770 and ask for Local 274 Benefits. Make sure your address is correct and ask for the COBRA enrollment documents.

STEP 2: Fill out 2 important forms



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

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours. ☐ Yes ☐ No
3. I elected (or am electing) COBRA continuation coverage. ☐ Yes ☐ No
4. 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 premium assistance). ☐ Yes ☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance ☐ Yes ☐ No

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.)

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

a.

1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours. ☐ Yes ☐ 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 →

Type or print name → Relationship to employee →

1. "Request for Treatment as an Assistance Eligible Individual"
2. "Dependent Information"

Request for Treatment as an Assistance Eligible Individual Form

completed "Request for Treatment as an Assistance Eligible Individual" to: [*Enter Name and Address*]

You may also want to read the important information about the rules for premium assistance included in the "Summary of the COBRA Premium Assistance Provisions Under the American Rescue Plan Act of 2021."

[*Insert Plan Name*]	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	[*Insert Plan Mailing Address*]

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number 702-123-4567
123 Fund Way Las Vegas, NV 89103	E-mail address (optional) johndoe@yahoo.com

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

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours.	☑ Yes ☐ No
2. I elected (or am electing) COBRA continuation coverage.	☑ Yes ☐ 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 premium assistance).	☑ Yes ☐ No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	☑ Yes ☐ No

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: John Doe Date: 4/19/2021

Type or print name: John Doe Relationship to Member: myself

FOR EMPLOYER OR PLAN USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason below and return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Fill out all sections marked here in yellow.

You are eligible if you can answer "yes" to all 4 questions.

If you're not sure how to answer any of these questions, call the Local 274 hotline at 267-603-1274 and leave a message. Someone will call you back to help

How do I answer questions 3 & 4?

“I am NOT eligible for other group health plan coverage”

- Mark **YES** if you cannot be covered by your spouse’s health plan
- Mark **YES** if you cannot be covered by health insurance from a 2nd job
- Otherwise, mark **NO**. This means you are eligible for other group coverage and NOT eligible for free COBRA

“I am not eligible for Medicare”

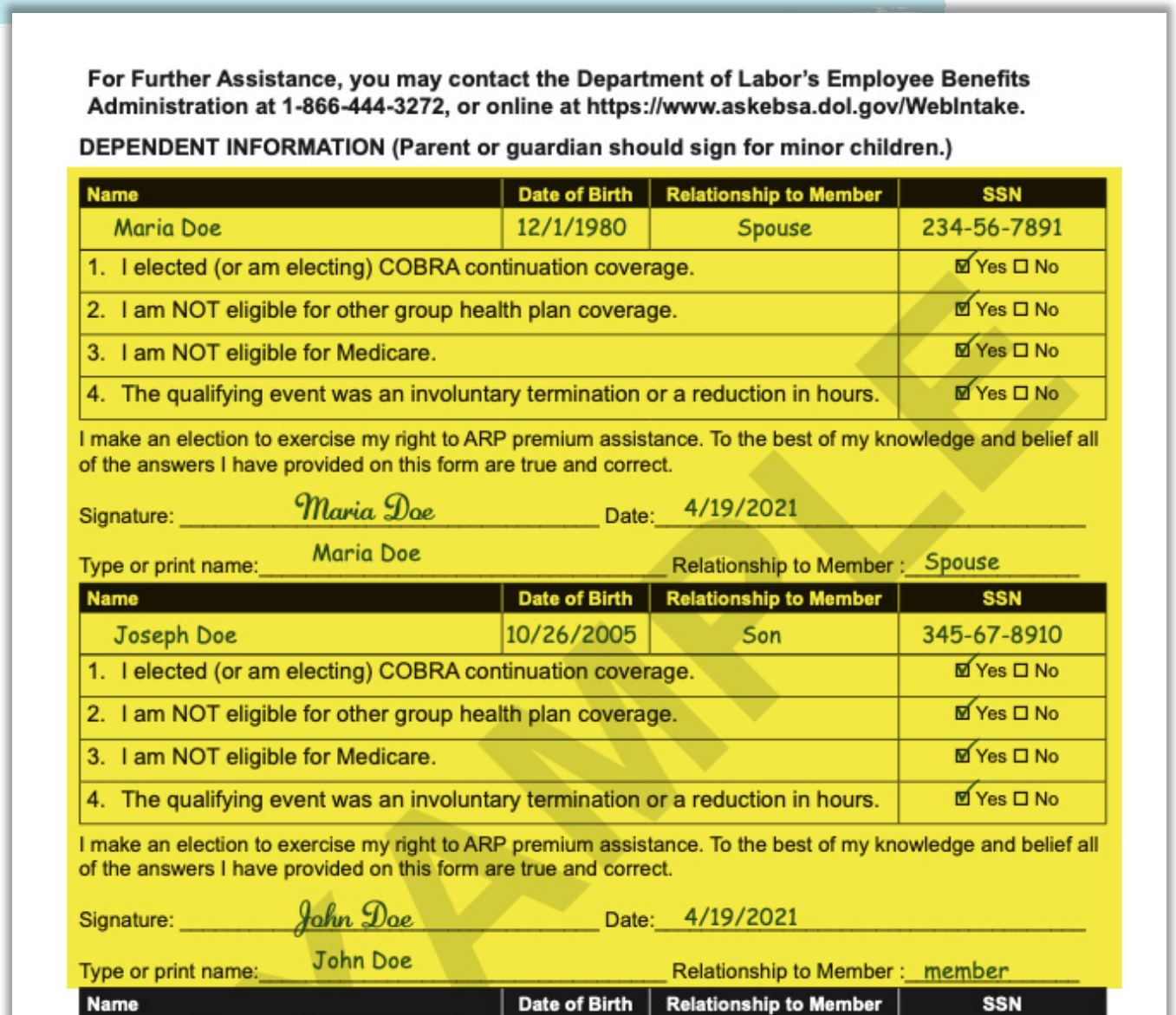
- Mark **YES** if you are under 65
- Otherwise, mark **NO**. This means you are eligible for Medicare and NOT eligible for free COBRA

Dependent Information Form

Fill out the yellow section for each dependent who was covered by your pre-pandemic health plan before you lost it.

They must be able to answer “yes” to all 4 questions to be eligible.

NOTE: Dependents should answer Question 4 based on your employment, not theirs.



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.)

Name	Date of Birth	Relationship to Member	SSN
Maria Doe	12/1/1980	Spouse	234-56-7891
1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.			☑ Yes ☐ 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: Maria Doe Date: 4/19/2021

Type or print name: Maria Doe Relationship to Member : Spouse

Name	Date of Birth	Relationship to Member	SSN
Joseph Doe	10/26/2005	Son	345-67-8910
1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.			☑ Yes ☐ 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: John Doe Date: 4/19/2021

Type or print name: John Doe Relationship to Member : member

Name	Date of Birth	Relationship to Member	SSN

TIPS: Dependent Information

Sign and date the section for each dependent under age 18.

Dependents older than 18 sign the form themselves.

Need more space? Write on the back!

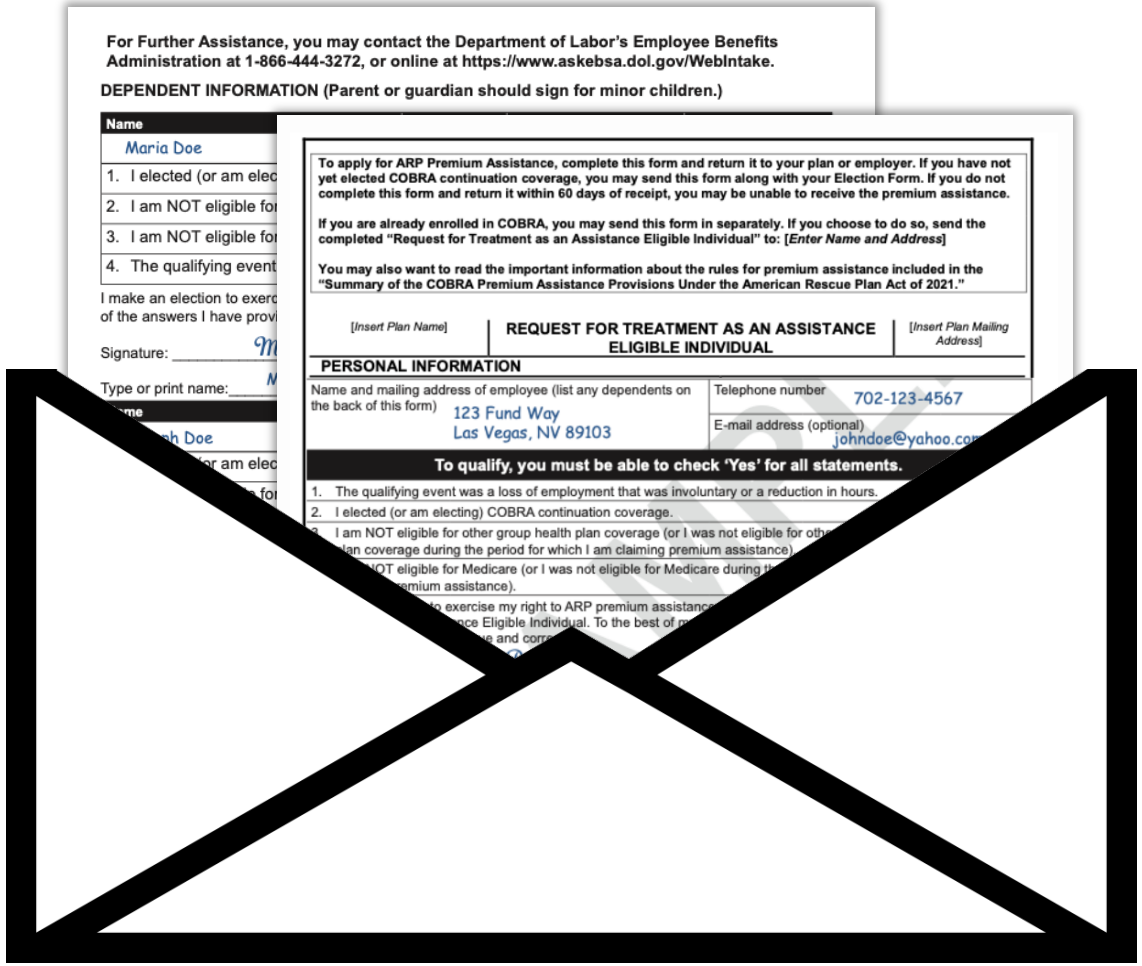
For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272, or online at https://www.askebsa.dol.gov/WebIntake.

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

Name	Date of Birth	Relationship to Member	SSN
Maria Doe	12/1/1980	Spouse	234-56-7891
1. I elected (or am electing) COBRA 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

STEP 3: Send back your forms!

Follow the instructions in your packet

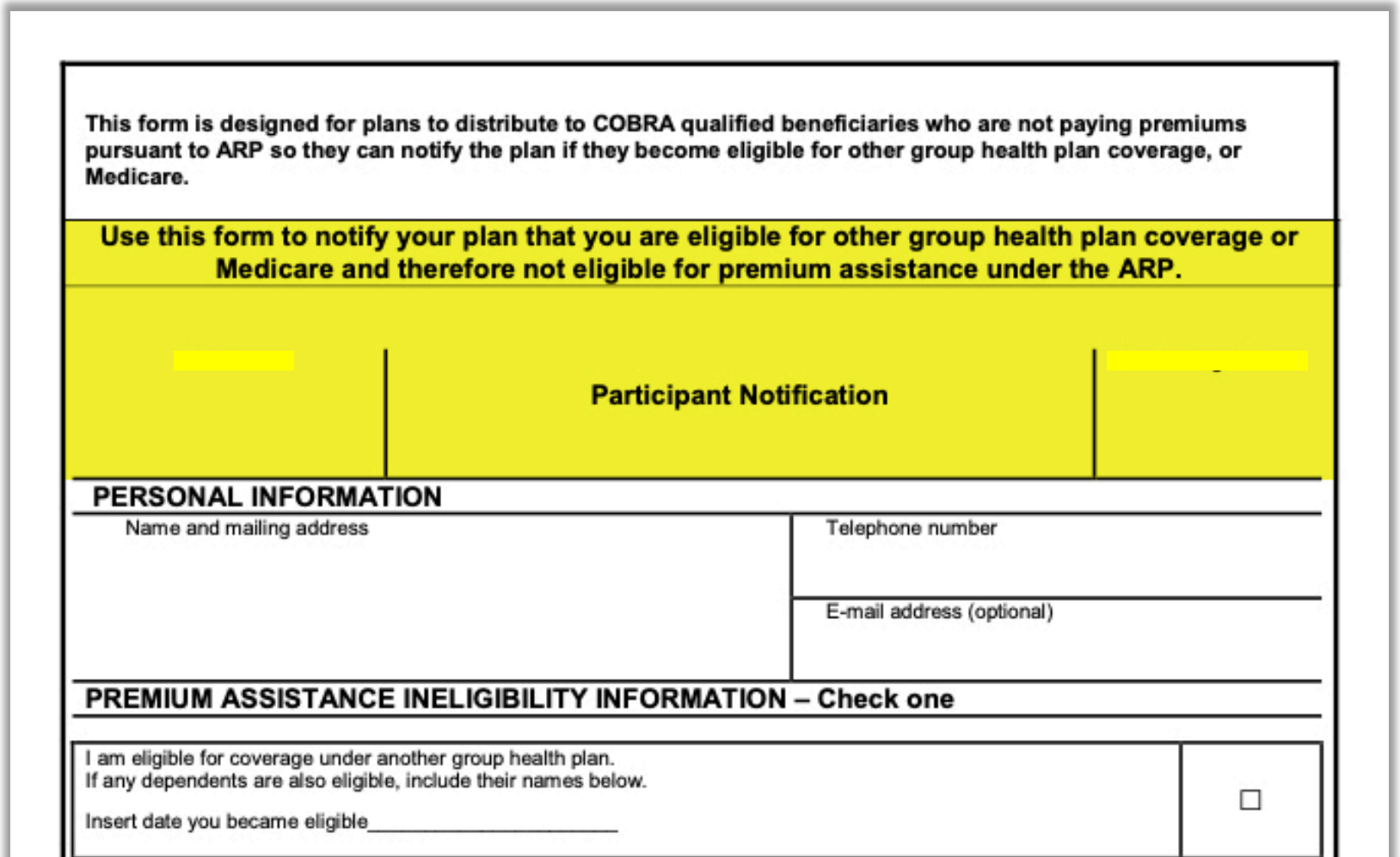


PARTICIPANT NOTIFICATION Form:
What do I do with this?

WARNING!

If you are eligible for Free COBRA and want to enroll DON'T FILL OUT THIS FORM!
It will cancel your enrollment.

Keep it in a safe place and only send it in if you become eligible for other group health insurance or Medicare before 9/30/21.



This form is designed for plans to distribute to COBRA qualified beneficiaries who are not paying premiums pursuant to ARP so they can notify the plan if they become eligible for other group health plan coverage, or Medicare.

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

Participant Notification

PERSONAL INFORMATION

Name and mailing address

Telephone number

E-mail address (optional)

PREMIUM ASSISTANCE 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_____

☐

TIPS: Participant Notification

Send this form if you become eligible for other group health insurance before 9/30/21, even if you do not sign up for it or it's too expensive.

- This DOES include Medicare (for people over age 65)
- This DOES NOT include Medicaid (for low-income and disabled people)

If you become eligible for other group health insurance but do not send this form, you may have to pay back the cost of your COBRA!