To apply for COBRA Premium Assistance under the American Rescue Plan Act of 2021 (ARP), complete this form and return it to the Local 802 Musicians Health Fund Office. The completed form may be sent by mail, fax or email to the Fund Office. (Contact information is below.)

If you have not yet elected COBRA continuation coverage, you may send this form along with your COBRA Election Form. If you do not complete this form and return it within 60 days of the date it is sent to you by mail, you may be unable to receive the premium assistance.

If you are already enrolled in COBRA, you may send this form in separately. (You do not need to send another COBRA Election Form.) The completed form may be sent by mail, fax or email to the Fund Office. The Fund Office address is 322 West 48th Street, 3rd Floor, NY, NY 10036, email address is hbp@local802afm.org and fax number is 212-245-2304.

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

LOCAL 802 MUSICIANS HEALTH FUND	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	322 West 48th Street, 3rd Floor New York, NY 10036

PERSONAL INFORMATION

Name and mailing address of employee/participant (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 the employee's (participant's) 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 → _____ Date → _____

Type or print name → _____ Relationship to participant/employee → _____

FOR FUND USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason in #3 below and 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. Individual did not experience a reduction in hours.	☐
3. Individual did not elect COBRA coverage.	☐
4. Other (please explain)	☐

Signature of Fund Representative:

→ _____ Date → _____

Type or print name → Gloria McCormick, Fund Administrator

Telephone number → 212-245-4802 ext 153 E-mail address → gmccormick@local802afm.org

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/Participant 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 the employee's (participant's) involuntary termination of employment 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/participant _____

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

b. _____

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 the employee's (participant's) involuntary termination of employment 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/participant _____

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

c. _____

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 the employee's (participant's) involuntary termination of employment or a reduction in hours.	☐ Yes ☐ No

I make an election to exercise my right to the 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/participant _____

Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021

President Biden signed H.R. 1319, the American Rescue Plan Act of 2021 (ARP), on March 11, 2021. This law subsidizes the full COBRA premium for "Assistance Eligible Individuals" for periods of coverage from April 1, 2021 through September 30, 2021.

To be eligible for the premium assistance, you:

- **MUST** have a COBRA qualifying event that is a reduction in hours or an involuntary termination of a covered employee's employment;
- **MUST** elect COBRA continuation coverage;
- **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 new employer or a spouse's employer. *

♦ IMPORTANT ♦

- ◊ If you do not elect to receive the premium assistance within 60 days of the date the Fund mails this form to you, you may be ineligible for the premium assistance.
- ◊ If you elect COBRA continuation coverage with premium assistance, and then become eligible for other group health plan coverage* or Medicare, you MUST notify the Fund in writing. If you fail to provide this notice, you may be subject to a penalty of $250 (or if the failure is fraudulent, the greater of $250 or 110% of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the Fund is due to reasonable cause and not due to willful neglect.
- ◊ Employers and plans that don't satisfy COBRA continuation coverage requirements may be investigated by the Department of Labor and may be subject to an excise tax under the Internal Revenue Code.
- ◊ If you elect COBRA continuation coverage and are eligible for the premium assistance, you cannot claim the Health Coverage Tax Credit. You also cannot qualify for a premium tax credit to help pay for coverage through a Health Insurance Marketplace®[1], such as on HealthCare.gov, for any months that you are enrolled in COBRA continuation coverage with or without the premium assistance.

For general information on your plan's COBRA continuation coverage, contact the Fund Office at 212.245.4802 or 322 West 48th Street, 3rd Floor, NY, NY 10036 or fax 212-245-2304 or hbp@local802afm.org.

For specific information on your plan's administration of the ARP premium assistance or to notify the plan of your ineligibility to receive premium assistance, contact the Fund Office at 212.245.4802 or 322 West 48th Street, 3rd Floor, NY, NY 10036 or fax 212-245-2304 or hbp@local802afm.org. For more information regarding ARP premium assistance and eligibility questions, visit:

https://www.dol.gov/cobra-subsidy or contact the Department of Labor at askebsa.dol.gov or 1-866-444-EBSA (3272)

---

* This restriction does not include coverage under a plan that provides only excepted benefits (such as dental or vision coverage), a qualified small employer health reimbursement arrangement, or coverage under a health flexible spending arrangement.

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.