# Request for Review If You Have Been Denied Premium Assistance

## Centers for Medicare & Medicaid Services (CMS)

You MUST use this form to request that the Centers for Medicare & Medicaid Services (CMS) review your **denial** of premium assistance to cover the cost of continuation coverage provided under COBRA laws applicable to Federal, State and local government employees and comparable State continuation coverage laws.

**If you fail to send us this completed form, we will NOT be able to review your case.**

**NOTE:** If your continuation coverage is provided through a private sector plan sponsored by an employer with at least 20 employees, you should direct your request for review to the Department of Labor. You can access the DOL website at www.dol.gov/COBRA or call toll-free at (866) 444-3272.

**GENERAL INFORMATION:**

If you lost your health benefits because you or a family member lost the job that provided your health coverage, you may be eligible for "continuation coverage" (sometimes called "COBRA") which lets you keep your health benefits temporarily after the job ends. If you are eligible for this type of coverage, a new law may help you pay for it. If you meet the requirements described below, you may qualify for "premium assistance," which will mean your premium will be only 35% of what it would be without the assistance.

**<u>This form is not an application for COBRA coverage</u>. Use this form only if your request for help paying the premium has been denied by your employer, group health plan, or insurer.**

**NOTE:** "COBRA" refers to the federal law that requires large private companies, and state or local government employers, to provide continuation coverage. To make it easier to understand, this form sometimes uses the word "COBRA" to mean **any** kind of continuation coverage. However, this might not be what it is called when it is offered to you. For example, if you worked for the Federal government it will be called "Temporary Continuation of Coverage" or "TCC."

Fill out the form **<u>completely</u>** and send it to the address listed below, or we cannot review your claim.

To be eligible for this assistance, you must meet ALL of the following requirements:

- You are eligible for continuation coverage because you or your family member lost a job between **September 1, 2008 and May 31, 2010**;
- You elect continuation coverage; and
- You request premium assistance.

If your request for premium assistance is denied by a Federal government employer, a state or local government employer with twenty or more employees, or a private employer under a State continuation coverage program, you can submit this form to CMS for an expedited review of the decision.
Follow the instructions included with this form and mail your completed request for review to:

Centers for Medicare and Medicaid Services
Appeals for Denial of Premium assistance under ARRA
7500 Security Boulevard
Mail Stop AR 18-50
Baltimore, Maryland 21244
Toll Free Phone No. (877) 267-2323
Option #4 ext. 61565.
phig@cms.hhs.gov

**APPLYING FOR REVIEW:**
When completing your application, answer all of the questions to the best of your knowledge and ability. Because we are required to complete the review in a short timeframe, we are asking for all the information that we think could be relevant to your request. Because a timely review is also to your advantage, please answer as completely as possible. However, we realize that you may not be able to answer every question, so, if you don't know the answer and can't get the information, check the box for "don't know." If you think you know the answer, but are not sure, answer as best you can but check the box marked "unsure." If a particular question does not apply to your case, check the box marked "N/A" ("not applicable.") Feel free to include copies of any documents that may help us in our review. Some examples of these documents are listed in the attached instructions. Since we may need to call you with questions, or to obtain more information, it's important that you provide us with the phone number where you can most likely be reached during the hours of 8 a.m. until 8 p.m. Eastern Time, as well as an alternate phone number, and an email address, if possible, where requested on the form.

If you have any questions you may contact us via e-mail at: phig @cms.hhs.gov or via phone (toll-free) at: (877) 267-2323 option #4 extension 61565. We cannot, however, accept your application for review over the phone or by e-mail.

## Instructions for the Request for Review If You Have Been Denied Premium Assistance as Provided by the American Recovery and Reinvestment Act of 2009

## Submit to: Centers for Medicare & Medicaid Services (CMS)

**Contact Information** Please complete the fields, if filing by mail or fax, by entering one letter or number per box. Please print clearly.

| *Name Mr. | X | Mrs. | | Ms. | |
|---|---|---|---|---|---|

| *Last | *First | Middle initial |
|---|---|---|
| SMITH | JOHN | T |

| *Street address |
|---|
| 1234 MAPLE AVENUE |

| *City | *State | *Zip |
|---|---|---|
| ANYTOWN | ST | 98765 |

**Lines D1-D4** When adding information on your dependents, please remember that a separate application(s) must be completed for any family member who is under a group health plan that is different than yours.

*Please answer Questions 1-11 by placing an X in the appropriate box (* [X] **).**

**Question #1** Answer YES to this question if you were covered by the group health plan. If you were not enrolled but should have been, answer UNSURE and explain the circumstances in the other information section at the end of the application. If a new dependent (or dependents) by birth, adoption, or placement for adoption joined the family of the employee at any time after the date of the qualifying event and a timely request to special enroll the new dependent(s) was made, answer YES to this question.

**Question #2** Answer YES if the employee's job termination occurred in the period from September 1, 2008 through May 31, 2010. Answer NO if the termination occurred before September 1, 2008 or after May 31, 2010.

**Question #2a** Answer YES if the employee's hours were reduced in the period from September 1, 2008 through May 31, 2010. Answer NO if the reduction of hours occurred before September 1, 2008 or after May 31, 2010.

**Question #3** Answer YES if the former employer has an ongoing health plan, if your former employer was acquired by another business that provides group health benefits or if the employee's former employer was a "trade or business" under common control. The acquiring business or other employers in the controlled group may have to offer you continuation coverage. If these situations do not describe your health plan, answer NO to this question. If you answer NO, you may have no plan from which to obtain continuation coverage. If so, the premium assistance would not be available to you.

**Question #4** For purposes of the premium assistance, qualifying events such as divorce, legal separation, entitlement to Medicare, a child ceasing to be a dependent child under the terms of the plan, or death of the employee are not terminations of employment. However, premium assistance may be available if the eligibility for continuation coverage is based on a reduction of hours in employment (for example, the employee went from full-time to part-time or could not work due to illness or disability) followed by an involuntary termination of employment occurring on or after March 2, 2010 and no later than May 31, 2010.

**Question #5** To be eligible for the premium assistance, the employee's job termination must have been involuntary. Whether a termination of employment is an involuntary termination of employment is determined based on all the relevant facts and circumstances. Examples of situations that may constitute an involuntary termination of employment are listed in Question 5. For help in determining if other situations are involuntary terminations, see pages 7 to 11 of IRS Notice 2009-27 at www.irs.gov/pub/irs-drop/n-09-27.pdf. Check the appropriate box that describes your situation or that of your family member. If none of the examples address the termination, answer YES in Item 5f and describe the circumstances of the termination in the **Other Information** box at the end of the application. Also please note: An employee and his or her dependents may not be eligible for continuation coverage if the employee was terminated from employment for gross misconduct.

**Question #6** If you were employed by a private-sector employer, answer NO. If your benefits were provided by the Federal government, a State or local governmental plan, or a church plan, answer YES.

**Question #7** Answer based upon the number of employees you believe the employer had. We recognize that you may not have the information to confirm this response. Generally, Federal COBRA only applies to group health plans maintained by employers that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year (January 1 to December 31), counting full- and part-time employees. If you answer YES to this question indicating that the employer had 20 or more employees and your continuation coverage would be through a private sector plan, you should direct your request for review to the Department of Labor. You can access the DOL website at www.dol.gov/COBRA or call toll-free at (866) 444-3272.

Please note: Although Federal COBRA rules do not apply to these small employers, the premium assistance applies to comparable continuation coverage that is provided pursuant to State law. If you answer NO to this Question indicating that your employer had fewer than 20 employees, your plan may be providing comparable State coverage. Contact your State's Department of Insurance (DOI) as a first step in determining whether State law applies to your coverage and qualifies you for premium assistance under ARRA. You can find a link to your State DOI at: www.naic.org/state_web_map.htm.

**Question #8** If you were offered continuation coverage in connection with your or your family member's job, select the answer that best addresses the status of your election. The election notice should be provided to qualified beneficiaries and should include information to help you understand continuation coverage, including the name of the plan's administrator. If you received such a notice, answer YES. You must be given an election period (starting on the later of the date the employer sends the notice to you (which, for instance, could be indicated by a postmark date) or the date you would lose coverage) to choose whether or not to elect continuation coverage. Did you let your plan know that you elected continuation coverage? If so, answer YES. If you requested continuation coverage but were denied, your plan must provide a notice that explains the reason for denying your request. Refer to this notice to answer the question and provide the reason in the **Other Information** section at the end of the application and attach a copy of the notice with your application.

Note that ARRA added a second election period for some individuals who experience an involuntary job termination from September 1, 2008 through February 16, 2009. If these individuals did not elect COBRA continuation coverage on their first opportunity, or elected continuation coverage but dropped it, they have a second opportunity to elect it. This additional election period does not apply to individuals eligible for continuation coverage under comparable State programs unless the State chooses to provide an additional election period.

**Question #9** If you received notice about the premium assistance in either the election form or a General Notice, answer YES. If you were denied the premium assistance, your plan may have provided you written notification of the reason for the denial, possibly on the form you used to request the premium assistance. If so, refer to that document to provide the reason in the **Other Information** section at the end of the application and attach a copy of the document with your application. If you have received no response to your request, you should answer "Unsure."

**Question #10** Answer YES if you are *eligible for coverage* under another group health plan or Medicare benefits. If you answer YES to this Question, you are not eligible for the premium assistance on the first date of eligibility for the other coverage. Note: if you are eligible for the premium assistance, you are required to notify the plan when you become eligible for Medicare or other group health coverage. Failure to do so may subject you to a penalty of 110 percent of the amount of any premium assistance.

**Question #11** 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 assistance may be recaptured by an increase in your income tax liability for the year. If you have continuation coverage, but wish to avoid this recapture, you may delay electing or permanently waive the premium assistance and pay the entire premium. If you exercised a permanent waiver, it cannot be withdrawn even if your income falls below these levels. For more information on the income tax recapture, consult your tax preparer or contact the IRS at www.irs.gov. If you waived the right to collect the premium assistance, answer YES and attach copies of any relevant documentation that you have.

**Information on the employer, plan sponsor, insurance company, and/or benefits administrator** Refer to the notice you received to find the information to use for this application. Attach a copy of the notice to your application.

**Other Information** Please provide what you were told about the reason(s) you were denied continuation coverage and/or the premium assistance as well as any other information you believe is important for the CMS to know in order to evaluate your application.

**Attachments** Since our review cannot begin until we receive a complete application, please attach copies of documentation that you believe would assist us in making a determination. Such documentation could include copies of one or more of the following items, if applicable: your election notice, your Request for Treatment as an Assistance Eligible Individual or other form used to request the premium assistance, your insurance card, payroll stubs showing deductions for health benefits, any documents detailing the date and circumstances of the termination of the employee's employment, or any documentation you were provided regarding the denial of the premium assistance.

# Request for Review If You Have Been

# Denied Premium Assistance

## Centers for Medicare & Medicaid Services (CMS)

**Applicant's Information *** *** Denotes required information**

*Name Mr. Mrs. Ms.

*Last *First Middle initial

*Street address

*City *State *Zip

*Best phone number to reach you between 8 a.m. and 8 p.m., EST

Alternate phone number(s)

*E-mail address

*Date employee's employment was terminated. (month/day/year)

*Date employer stopped paying for the applicant's costs of health insurance under group health plan. (month/day/year)

Applicant's relationship to employee

Self Spouse Child Other

If applicant is not the employee, provide the name of the employee

*Name Mr. Mrs. Ms.

*Last *First Middle initial

Names of dependents for whom you are also requesting a determination regarding a denial of premium assistance, if any. **Reminder:** if any family member is covered under a different plan than yours, complete a separate application for him or her.

| Name | Relationship | Age |
|---|---|---|
| D1) | | |
| D2) | | |
| D3) | | |
| D4) | | |

Attach an additional page if you need to add more dependents to the list.

**Note: The applicant (person requesting review of a denial of premium assistance) may either be the employee or a member of the employee's family who has received continuation coverage through the employer's group health plan. In some instances, a former employee's dependents may still be able to continue such health insurance--and receive assistance with premiums paid for that health insurance--even though the employee is not continuing such coverage.**

| ***Eligibility:*** *Please see instructions for assistance in answering the questions below.* | ***Yes*** | ***No*** | ***Unsure or N/A*** |
|---|---|---|---|
| *1. Were you covered by the employer's group health plan on the day before the employee was terminated? Also answer YES if you were covered by the employer's group health plan on the day before the employee experienced a reduction of hours in employment. If this is being answered for a new dependent (or dependents) born to, adopted by, or placed for adoption with the employee, refer to the instructions to answer the question for the new dependent. | | | |
| *2. Was your or your family member's employment terminated in the period from September 1, 2008 through May 31, 2010? | | | |
| a. If you believe you qualify based on a reduction of hours followed by a termination, did the reduction of work hours experienced by you or your family member occur in the period from September 1, 2008 through May 31, 2010? | | | |
| *3. Is there an ongoing health plan? Are employees who currently work where you or your family member used to work still covered by health insurance that the employer--or another company--provides? (Or is there another employer (such as a parent company) which may be responsible for providing continuation coverage to you?) | | | |
| *4. Are you eligible for continuation coverage because of the loss of your job or your family member's job? If so, answer YES. Also answer YES if you are or were eligible for continuation coverage because of the employer's reduction of hours, but the employee was later terminated from employment on or after March 2, 2010 through May 31, 2010.<br>If you are eligible for continuation coverage because of divorce, legal separation, entitlement to Medicare, loss of dependent status, or death of the covered employee, answer NO. | | | |

**PLEASE NOTE:** If you answered NO to any of the Questions above (1-4) you may not be eligible for continuation coverage premium assistance. If you have questions about the requirements for premium assistance, or otherwise need assistance completing this application, please contact MAXIMUS Federal Services toll-free at (866) 400-6689.

| | ***Yes*** | ***No*** | ***Unsure or N/A*** |
|---|---|---|---|
| *5. Was the employee's job termination involuntary? | | | |
| a. Was it a permanent layoff? | | | |
| b. Was it a temporary layoff with possible recall? | | | |
| c. Was it a buyout or severance package in anticipation of a layoff? | | | |
| d. Did the employee resign as a result of a major change in the geographic location of employment? | | | |
| e. Did the employee's employment end while the employee was absent due to illness or disability? | | | |
| f. Other reason the employment was terminated? – Check "Yes" and please describe in the **Other Information** box at the end of the application. | | | |

For more information that may help you to answer the above questions, see pages 7 - 11 of the IRS Notice 2009-27 at www.irs.gov/pub/irs-drop/n-09-27.pdf.

| | | | |
|---|---|---|---|
| *6. Did you or your family member work for the Federal government, a State or local government, or a church? | | | |
| *7. Did your former employer or your family member's former employer have 20 or more employees in the calendar year prior to the year in which you or your family member was terminated? | | | |
| *8. Regarding continuation coverage | **Yes** | **No** | **Unsure or N/A** |
| a. Did you get a notice informing you of your right to elect continuation coverage? | | | |
| b. Did you send in a form requesting, or electing, coverage? | | | |
| c. Were you denied continuation coverage? If yes, explain the reason in the **Other Information** box at the end of the application. Attach copies of all relevant documents. | | | |
| d. If you received continuation coverage, what date did it start? (month/day/year) | | | |
| e. If you received continuation coverage, what date did it end? (month/day/year) | | | |
| Explain the reason your continuation coverage ended in the **Other Information** box at the end of the application. Attach copies of all relevant documents. | | | |
| *9. Regarding the premium assistance | **Yes** | **No** | **Unsure or N/A** |
| a. Did you receive a notice informing you that you may be eligible for premium assistance? | | | |
| b. Did you apply for the premium assistance? (For instance call, write, or e-mail the employer or its group health plan or send in the form called Request for Treatment as an Assistance Eligible Individual.) | | | |
| c. Did you receive a notice informing you about the premium assistance extension and the opportunity to retroactively pay the 35 percent payment due on certain premiums related to the extension of the assistance from 9 to 15 months? | | | |
| d. Were you denied the premium assistance or granted the premium assistance, but denied the additional 6 months of premium assistance provided by the extension? If yes, explain the reason in the **Other Information** box at the end of the application below. Attach copies of all relevant documents. | | | |
| *10. At any time after you or your family member lost his or her job were you (or any dependents) eligible to receive health insurance coverage under any other group health plan (such as a plan sponsored by a later employer or a spouse's employer) or Medicare? If yes, please note the date you (or any dependents) became eligible for the other coverage. (month/day/year) | | | |
| *11. Did you sign any form saying you don't want the premium assistance? (In other words, did you exercise any waivers of your right to the premium assistance?) | | | |

## Fill in the information below that applies to you.

***Employer Information:*** *Please enter the following information about the employer that sponsors the group health plan as completely as possible and attach any supporting documentation you have. Note: This information may be found on the continuation coverage notice you received.*

*Name of employer

Best person at employer to contact

*Name Mr. Mrs. Ms.

*Last *First Middle initial

*Street address

*City *State *Zip

*Phone number - -

Fax number - -

Employer's e-mail address

Employer's website address

Employer's "Employer Identification Number" (EIN).
(This number can often be found on your W2 or in your Summary Plan Description (SPD))

***Plan Sponsor Information:*** *If the employer is not sponsoring the group health plan, please enter the following information about the organization (such as a union or joint board of trustees) that is the plan sponsor. For instance, if you work for a school district, your state may sponsor your group health plan. Note: This information may be found on the continuation coverage notice you received.*

*Name of plan sponsor

Best person at plan sponsor to contact

*Name Mr. Mrs. Ms.

*Last *First Middle initi

*Street address

*City *State *Zip

*Phone number

Fax number

Plan sponsor's e-mail address

Plan sponsor's website address

***Parent Company or Purchaser Information:*** *If another company such as a parent company or a company that recently bought the employer, may be responsible for providing continuation coverage, please provide as much information as possible about that company and its connection to the employer. (Attach an additional sheet, if needed.)*

*Parent company or purchaser information name

Best person at parent co./purchaser to contact

*Name Mr. Mrs. Ms.

*Last *First Middle initial

*Street address

*City *State *Zip

*Phone number

Fax number

Parent co./Purchaser's e-mail address

Parent co./Purchaser's website address

***Insurance, HMO or Benefits Administrator Information:*** *If applicable, please enter the following information as completely as possible about the insurance company, health maintenance organization (HMO) or benefits administrator that administers benefits for your employer's group health plan and attach any supporting documentation you have.*

*Name of plan (ex. ABC Insurance Co PPO, Company Group Plan)

Name of insurer or benefits administrator

Best person to contact

*Name Mr. Mrs. Ms.

*Last *First Middle initial

*Street address

*City *State *Zip

*Phone number - -

Fax number - -

Group number of insurance/plan

Applicant's plan ID number

Plan e-mail address

Plan website address

**Other information:** **It would be helpful if you could provide as much information as possible about your situation. If you have not already done so in response to earlier questions in this application, please provide information about any of the following:**

- **What you were told about the reason(s) you were denied continuation coverage and/or the premium assistance;**
- **Why you think you were denied either;**
- **Who, if anyone, told you or your family member that you or s/he had lost the job and what that person said;**
- **Any other people who were around when you or your family member learned about the job loss; and**
- **Any other information you believe is important for the Centers for Medicare & Medicaid Services to know in order to evaluate your application. Such information may include one or more of the following documents: your COBRA election notice, your Request for Treatment as an Assistance Eligible Individual or other paper used to request the premium assistance, your insurance card, payroll stubs showing deductions for health benefits, any documents detailing the date and circumstances of the termination of the employee's employment, or any documentation you were provided regarding the denial of the premium assistance. Please do not send in originals or your only copy.**

Under the penalty of perjury, I declare that I have examined this application, including any accompanying attachments, and to the best of my knowledge and belief, it is true, correct and complete. I hereby authorize the release of the information contained in and attached to this application, as well as any additional oral or written information that may be collected in connection with this review process, to any other parties to this review, including the health plan and my or my family member's former employer. I further authorize the individuals involved in processing this review to discuss with other individuals such information as they may deem necessary in resolving this review.

Signature: _____ Date: _____

Type or print name: _____

**Privacy Act Notice**

The Privacy Act of 1974 requires that when we ask you for information we tell you our legal right to ask for the information, why we are asking you for it, and how it will be used. We must also tell you what could happen if we do not receive it and whether your response is voluntary, required to obtain a benefit, or mandatory. Our legal right to ask for the information is section 3001(a)(5) of the American Recovery and Reinvestment Act of 2009 (ARRA). We are asking for this information to comply with the provisions of ARRA and to enable the Secretary of Health and Human Services to make a determination on your application for the Secretary's expedited review of the denial of your request for treatment as an assistance eligible individual. If you do not provide the requested information, you will not be eligible for such review. We do not sell the information that we collect. The personal information that you give us will be used only in connection with the Secretary's expedited review of the denial of your request for treatment as an assistance eligible individual.

We use contractors to perform various website and database functions. When we do, we make sure that the agreement language with the contractor ensures the security, confidentiality and integrity of any personal information to which the contractor may have access in the course of contract performance.

While online filing is secure, electronic mail is not secure. Therefore, we suggest that you don't send personal information to us by email. We will only send general information to you by email.

We may disclose the information you give us if authorized or required by Federal law, such as the Privacy Act. We may also disclose this information to the other parties to this review, including your health plan and, in many cases, to the employee's former employer, as well as to the courts as a part of the record on any appeal. You may have access to any of the information we collect about you. Also, if you provide false or fraudulent information, you may be subject to criminal prosecution. See section 1027, Title 18, U.S. Code (False statements and concealment of facts in relation to documents required by ERISA) and section 1001, Title 18, U.S. Code (Fraud and False Statements - Statements or entries generally). Other penalties may also apply.

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1062. The time required to complete this information collection is estimated to average one (1) hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.