



## State of New Jersey

DEPARTMENT OF BANKING AND INSURANCE  
SMALL EMPLOYER HEALTH BENEFITS PROGRAM  
PO Box 325  
TRENTON, NJ 08625-0325

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

TEL (609) 633-1882  
FAX (609) 633-2030

THOMAS B. CONSIDINE  
*Commissioner*

### ADVISORY BULLETIN 10-SEH-02

March 16, 2010

To: SEH Program Member Carriers that Issue Coverage  
SEH Program Interested Parties

From: Ellen DeRosa  
Executive Director

**Re: Carrier Obligations in the Implementation of the American Recovery and Reinvestment Act of 2009 as amended by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 for New Jersey Small Employers that are Subject to New Jersey Continuation**

On March 9, 2009 we issued [Advisory Bulletin 09-SEH-01](#) discussing features of the American Recovery and Reinvestment Act of 2009 (ARRA) as related to New Jersey Continuation. On March 26, 2009 we issued [Advisory Bulletin 09-SEH-02](#) to further address the vital role New Jersey small employer carriers must play in the implementation of the premium reduction for former employees electing continuation under N.J.S.A. 17B:27A-27. On November 16, 2009 we issued [Advisory Bulletin 09-SEH-04](#) to address guidance concerning the timing for the request for treatment as an assistance eligible individual. On January 4, 2010 we issued [Advisory Bulletin 10-SEH-01](#) to address the amendments to ARRA made by the Department of Defense Appropriations Act, 2010 which extended the premium reduction for an additional 6 months and allowed for terminations of employment through February 28, 2010.

The purpose of this Advisory Bulletin 10-SEH-02 is to address the amendments made by the Temporary Extension Act of 2010.

#### **Date of Involuntary Termination of Employment**

ARRA originally considered involuntary terminations of employment between September 1, 2008 and December 31, 2009 which was later extended until February 28, 2010. The Temporary Extension Act of 2010 further extends the date until March 31, 2010. A variety of sources suggest that the March 31, 2010 date will be extended. Recognizing the challenges with changing forms and experience with extensions not necessarily enacted prior to the conclusion of an existing termination date, I drafted the forms to use with ARRA to state March 31, 2010 or

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such later date as may be specified in Federal law. In the event of a subsequent extension our forms will not be immediately out of date.

### **Reduction in Hours Followed by Involuntary Termination of Employment**

The Temporary Extension Act of 2010 provides that an employee whose hours were reduced between September 1, 2008 and March 31, 2010 triggering a continuation right and who subsequently is involuntarily terminated between March 2, 2010 and March 31, 2010 is eligible for the premium reduction as a result of the involuntary termination of employment. The employer would have notified the carrier to take the employee off the plan at the time hours were reduced below 25 hours per week. The employee may or may not have elected continuation at that time. Once an employee is covered under continuation or if the employee chose not to elect continuation, the employer would not ordinarily have any reason to notify the carrier of a subsequent termination from employment since that termination would not result in a coverage status change. With the Temporary Extension Act of 2010, it is very important that the carrier be notified of the subsequent termination of employment.

There are several ways a carrier may learn of a subsequent termination of employment.

- The employer may give notice to the carrier of the subsequent involuntary termination of employment.
- The broker for the employer may be aware of the termination and give notice to the carrier.
- A person who is involuntarily terminated following a reduction in hours may call the carrier directly.
- It is possible a carrier may learn of the involuntary termination of employment through some other source.

Notice given within a reasonable period of time following the termination or employment should be accepted. The carrier can expect the notice to include the former employee's name, termination date and identification number. The notice can be in writing or by phone call. Upon receipt of notice of an involuntary termination that was between March 2, 2010 and March 31, 2010 (or such later date as may be stated in Federal law) the carrier should send the forms identified below.

The Temporary Extension Act of 2010 recognizes the loss of coverage that resulted from the reduction in hours as the qualifying event which means the 18 months of continuation coverage are measured from that date. The premium reduction can overlap with some of that period and is available for up to 15 months beginning with the first period of coverage on or after the date of the involuntary termination of employment. The premium reduction does not apply to any period of coverage prior to the involuntary termination of employment. Depending on the date of the loss of coverage due to the reduction in hours, it is possible some former employees will have fewer than 15 months remaining for continuation coverage and thus they will not have the opportunity for the full 15 months of premium reduction. For example, a person whose hours were reduced January 1, 2009 would have commenced continuation as of January 1, 2009 and continuation will end June 30, 2010. If that person is involuntarily terminated from employment as of March 15, 2010 the first period of coverage would generally begin April 1, 2010 and thus the person would get the premium reduction for April, May and June. Continuation will end June 30, 2010 as will the premium reduction.

The Temporary Extension Act of 2010, like ARRA as originally enacted, allows a second chance to elect continuation. If an employee's hours were reduced below 25 hours per week and the person either did not elect continuation or elected then dropped continuation, the subsequent involuntary termination of employment triggers an opportunity to elect continuation. The 18-month period is measured from the loss of coverage due to the reduction in hours. The former employee who did not previously elect and maintain continuation picks up the continuation coverage as of the first period of coverage on or after the date of the termination of employment. The former employee does not pay any continuation premium for the period between the loss of coverage and the date the continuation begins which means there is no coverage during that period. The gap in coverage during this period will not count in determining whether the person has had a lapse in coverage of more than 90 days for purposes of pre-existing conditions credit.

The period for electing New Jersey continuation is 30 days from the date coverage ends. In order to give meaning to this second chance for continuation a special election period is necessary. Given that a former employee may not even be aware there is a second chance to make an election until he or she receives a package of information from the carrier, the 30 days for the election of continuation should be measured from the date notice is received.

### **What Carriers Must Mail**

Attached is an amended notice package. In addition to updating the existing notice and forms for persons whose employment terminates on or before March 31, 2010, there are two additional documents for persons who experience a reduction in hours followed by an involuntary termination of employment. Since carriers have already mailed notices of the 6-month extension to all assistance eligible individuals, this current package of forms does not include those notices. Carriers that might need to refer to such notices can find them with Bulletin 10-SEH-01.

### **Newly terminated employees (no prior reduction in hours)**

Carriers should mail the amended notice and forms upon receipt of information that an employee has been terminated.

- New Jersey Continuation Coverage Notice of Continuation Option and Election of Premium Reduction
- New Jersey Continuation Election Form
- Form for Switching Plan Options
- Employer Information and Verification
- Request for Treatment as an Assistance Eligible Individual
- Participant Notification

### **Terminated employees (following a reduction in hours)**

Carriers should mail the amended notice and forms upon receipt of information that an employee has been terminated.

- New Jersey Continuation Coverage Reduction in Hours Followed by Termination of Employment
- New Jersey Continuation Election Form (specific form that addresses reduction followed by termination)
- Form for Switching Plan Options (same as for newly terminated employee)
- Employer Information and Verification (same as for newly terminated employee)

- Request for Treatment as an Assistance Eligible Individual (same as for newly terminated employee)
- Participant Notification (same as for newly terminated employee)

### ***General Information***

Information concerning ARRA is found on the U.S. Department of Labor's website which is <http://www.dol.gov/ebsa/COBRA.html>

CMS's website is <http://www.cms.hhs.gov/COBRAContinuationofCov>.

Maximus is the contractor that handles premium assistance appeals. The website is <http://www.continuationcoverage.net>.

The IRS website also contains a lot of good information:  
<http://www.irs.gov/newsroom/article/0,,id=204505,00.html?portlet=7>.

Information concerning New Jersey Continuation and ARRA is found on the Department of Banking and Insurance website which is [http://www.state.nj.us/dobi/division\\_consumers/insurance/arra.html](http://www.state.nj.us/dobi/division_consumers/insurance/arra.html)

### ***Questions***

If you have any questions concerning New Jersey continuation or the treatment of assistance eligible individuals please contact me by email at [ellen.derosa@dobi.state.nj.us](mailto:ellen.derosa@dobi.state.nj.us) or by phone at 609-633-1882 ext. 50302.

*[Carrier letterhead/logo]*  
*[Use this notice for new terminations]*

## **New Jersey Continuation Coverage Notice of Continuation Option and Election for Premium Reduction**

*[Date][Or, if a carrier wants to make this a generic piece, omit the date]*

Dear Former Employee: *[Carriers may include employee name or may leave as generic]*

This notice contains important information about your option to continue your medical coverage under your former employer's group health benefits plan. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 reduces the continuation premium in some cases. According to information we received from your former employer, your medical coverage terminated between September 1, 2008 and March 31, 2010. You may be eligible for a temporary ARRA premium reduction for up to fifteen months. To help determine whether you can get the ARRA premium reduction you should read this notice and the attachments very carefully.

*Involuntary Termination of Employment between April 19, 2009 and March 31, 2010 or such later date as may be specified in Federal law*

If you think you meet the criteria for the premium reduction, and have elected to continue your coverage under New Jersey Continuation, complete the "Application for Treatment as an Assistance Eligible Individual" and mail it to your former employer. Your mailing to the former employer must also include the Employer Information and Verification Form. Coverage will be effective as of the day after your coverage ended, meaning there will be no break in coverage. The premium reduction will last no more than 15 months. Such 15-month premium reduction period neither extends nor reduces the 18 months available for New Jersey Continuation.

If your former employer offers more than one medical plan option to active employees you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or less than the cost for the plan you had when your coverage ended. Check with your former employer regarding alternate options and the cost for such options. The election for the alternate plan must be noted on the New Jersey Continuation Election Form and the Form for Switching Plan Options must be attached

You will be required to pay the first premium which will cover the period from the date continuation coverage begins through the current period *within 30 days* of the date you make the election for New Jersey Continuation. Send all premium payments to your former employer who will add such payments to the premium being sent to us (the carrier) for the coverage for active employees. If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. *[Specific premium information is enclosed.]*  
*[Carriers, if it is not enclosed, say how the former employee can get it]*

Mail these completed forms to your former employer.

- ✓ New Jersey Continuation Election Form (if you are electing continuation now)
- ✓ Form for Switching Options (if you are electing another option)
- ✓ Request for Treatment as an Assistance Eligible Individual
- ✓ Employer Information and Verification

If you have any questions concerning an election for New Jersey Continuation or the premium reduction, please contact *[carrier member services at phone]*

Sincerely,  
*[Carrier]*

## New Jersey Continuation Election Form

For involuntary terminations of employment between September 1, 2008 and March 31, 2010 or such later date as may be specified in Federal law

**Instructions:**

This Election Form can ONLY be used to elect New Jersey Continuation in the event of in the event of an *involuntary* termination of employment occurring between September 1, 2008 and March 31, 2010 or such later date as may be specified in Federal law. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

To elect to continue medical coverage under New Jersey Continuation, the terminated employee must complete the following form and mail it to the former employer. The completed election form must be postmarked **within 30 days** of the date your coverage ended.

If medical coverage under New Jersey Continuation is already in effect, do not complete this election form again.

I elect to continue medical coverage for myself and all dependents listed in item II below.

**I. Terminated Employee Information**

Name: \_\_\_\_\_ SS# \_\_\_\_\_ First  
MI Last or other identifier

Address \_\_\_\_\_  
Street City State Zip Code

Dates: \_\_\_\_\_  
Employment Ended Medical Coverage Ended

Was the termination an involuntary termination of employment?  Yes  No

If No, do not submit this form. Contact your former employer for information on New Jersey Continuation.

**II. Dependent Information**

List all dependents who were covered under your former employer's medical plan on the date before your employment was involuntarily terminated and who you wish to cover under New Jersey Continuation.

*Note:* Dependent coverage can ONLY be continued if the former employee elects to continue coverage for him/herself.

Name	Date of Birth	Relationship To employee	SS# or other identifier
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**III. Plan Selection**

Check one

Same coverage that was in effect on the day before coverage ended or such other replacement coverage as is currently offered to active employees

Alternate coverage. You must complete the Form for Switching Plan Options

**IV. Signature**

\_\_\_\_\_  
Signature of Terminated Employee

\_\_\_\_\_  
Date

## Form for Switching Plan Options

For involuntary terminations of employment between September 1, 2008 and March 31, 2010 or such later date as may be specified in Federal law

### **Instructions:**

This Form for Switching Plan Options can ONLY be used if you have elected or are electing New Jersey Continuation following an *involuntary* termination of employment occurring between September 1, 2008 and March 31, 2010 or such later date as may be specified in Federal law.

Contact your former employer and ask the following:

1. Does the employer offer a medical plan for active employees other than the plan under which you were covered prior to your termination of employment? If yes, proceed to item 2. If no, you have no opportunity to switch plan options.
2. Is the cost for the alternate plan the same or less than the cost for the plan under which you were covered prior to your termination of employment? If yes, proceed to item 3. If no, you have no opportunity to switch plan options.
3. Ask your former employer for the name of the carrier issuing the alternate plan, the exact plan name of the alternate plan along with information on the applicable copayments, deductible and coinsurance. If the employer is not sure of this information, suggest that he or she ask the broker for these details. The carrier will verify the availability of the alternate plan.

For new elections of New Jersey Continuation the alternate plan will be effective as of the effective date of continuation coverage.

If New Jersey Continuation is already in effect, the alternate plan will be effective as of the start of the first period of coverage on or after this election is received.

I elect New Jersey Continuation coverage for myself and my covered dependents under the alternate plan option as stated below.

### **I. Terminated Employee Information**

Name: \_\_\_\_\_ SS# \_\_\_\_\_ First  
MI Last or other identifier

Address \_\_\_\_\_  
Street City State Zip Code

Dates: \_\_\_\_\_  
Employment Ended Medical Coverage Ended

### **II. Alternate Plan Election**

Name of carrier issuing alternate plan: \_\_\_\_\_

Name of alternate plan: \_\_\_\_\_

Copayment: \_\_\_\_\_ Deductible: \_\_\_\_\_ Coinsurance: \_\_\_\_\_

### **III. Signature**

\_\_\_\_\_  
Signature of Terminated Employee

\_\_\_\_\_  
Date

**American Recovery and Reinvestment Act of 2009 (ARRA)  
Employer Information and Verification**

Dear Former Employer:

I received information from the insurance carrier regarding New Jersey Continuation coverage and have completed the "Request for Treatment as an Assistance Eligible Individual" The carrier also sent me this Employer Information and Verification to send to you to complete.

In order for the carrier to determine if I am eligible for the ARRA Premium Reduction please complete the following and return it to the carrier along with my Request for Treatment as an Assistance Eligible Individual and my continuation election form, if it is enclosed. Please complete and mail immediately so the carrier may process my request.

Please understand that your cooperation in providing this information will **not** result in you being required to pay the 65% reduction. The carrier will pay it. Without this information I may not be able to take advantage of the premium reduction. While the carrier and I anticipate you will cooperate, the New Jersey Department of Labor and Workforce Development has indicated it will take necessary action if an employer fails to cooperate. Further, if you fail to complete the Employer Information and Verification the carrier will deny my request for treatment as an assistance eligible individual which will entitle me to appeal rights with the U.S. Department of Health and Human Services.

Former Employee Name: \_\_\_\_\_  
Employee fill in your name

**To be completed by Former Employer**

Date Employment Terminated: \_\_\_\_\_

Was the termination an *involuntary* termination of employment?  Yes  No

If no, the premium reduction is not available. Briefly describe the circumstances of the termination:

\_\_\_\_\_

Date medical coverage terminated: \_\_\_\_\_

Do you currently offer group medical coverage to active employees?  Yes  No

If no, continuation is not available and neither is the premium reduction.

Has your company continuously maintained group medical coverage under our plan or under a succeeding carrier's plan since the date the employee was terminated?  Yes  No

If no, continuation is not available and neither is the premium reduction.

Do you offer more than one plan option to employees?  Yes  No

If yes, name the carriers and identify the other plans.

**Carrier name**

**Plan** (name and brief description)

\_\_\_\_\_

\_\_\_\_\_

Is your current group medical coverage issued by another carrier?  Yes  No

If yes, identify the carrier \_\_\_\_\_

If yes and your former employee was involuntarily terminated from employment between September 1, 2008 and March 31, 2010, or such later date as may be specified in Federal law, please send a copy of this

form to this other carrier at the address you currently use for new enrollments so the former employee may secure New Jersey Continuation coverage and the premium reduction under that carrier's plan.

\_\_\_\_\_  
Employer – Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer – Printed name

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
E-mail

**Instruction to Former Employer:** Send this Employer Information and Verification form along with the New Jersey Continuation Election Form, if any, Form for Switching Plan Options, if any and the Request for Treatment as an Assistance Eligible Individual to *[carrier, address]*.

To apply for ARRA Premium Reduction, complete this form and send it to your former employer along with your Election Form if newly electing New Jersey Continuation. Also send the Employer Information and Verification form to your former employer.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" along with the Employer Information and Verification to your former employer.

[Insert Carrier Name]

**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

[Insert Carrier Mailing 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.  | <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 March 31, 2010 or such later date as may be specified in Federal law.               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I elected (or am electing) continuation coverage.  | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 a reduced premium). | <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 |

I make an election to exercise my right to the ARRA Premium Reduction for myself and my eligible dependents. 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/print name → \_\_\_\_\_ Relationship to employee → \_\_\_\_\_

**FOR CARRIER USE ONLY**

This application is:  Approved  Denied  Approved for some/denied for others (explain in #4 below)

Specify reason below and then 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. The involuntary loss did not occur between September 1, 2008 and March 31, 2010 or such later date as may be specified in Federal law.
3. Individual did not elect continuation coverage.
4. Other (please explain)

Signature of party responsible for continuation coverage administration

→ \_\_\_\_\_ Date → \_\_\_\_\_

Type/print name → \_\_\_\_\_

Telephone number → \_\_\_\_\_ E-mail address → \_\_\_\_\_

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

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

a. \_\_\_\_\_

- |  |  |
|--|--|
| 1. The former employee elected (or is electing) continuation coverage.     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I (the dependent) am NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I (the dependent) am NOT eligible for Medicare.                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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/print name → \_\_\_\_\_                      Relationship to employee → \_\_\_\_\_

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

b. \_\_\_\_\_

- |  |  |
|--|--|
| 1. The former employee elected (or is electing) continuation coverage.     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I (the dependent) am NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I (the dependent) am NOT eligible for Medicare.                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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/print name → \_\_\_\_\_                      Relationship to employee → \_\_\_\_\_

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

c. \_\_\_\_\_

- |  |  |
|--|--|
| 1. The former employee elected (or is electing) continuation coverage.     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I (the dependent) am NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I (the dependent) am NOT eligible for Medicare.                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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/print name → \_\_\_\_\_                      Relationship to employee → \_\_\_\_\_

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

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

[Carrier Name]	<b>Participant Notification</b>	[Carrier mailing address]
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**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. <i>If any dependents are also eligible, include their names below.</i>  Insert date you became eligible: _____	<input type="checkbox"/>
I am eligible for Medicare.  Insert date you became eligible: _____	<input type="checkbox"/>

**IMPORTANT**

**If you fail to notify your carrier 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/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:*

_____	_____
_____	_____

*[Carrier letterhead/logo]*

*[Use this notice for any person who previously qualified for New Jersey Continuation as a result of a reduction in hours, and whose employment is terminated between March 1, 2010 and March 31, 2010, or such later date as may be specified in Federal law]*

**New Jersey Continuation Coverage  
Reduction in Hours followed by Termination of Employment**

*[Date][Or, if a carrier wants to make this a generic piece, omit the date]*

This notice contains important information about your option to continue your medical coverage under your former employer's group health benefits plan. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010 reduces the continuation premium in some cases. According to information we received from your former employer, you experienced a reduction in hours between September 1, 2008 and March 31, 2010 and a subsequent termination of employment between March 2, 2010 and March 31, 2010 or such later date as may be specified in Federal law. You may be eligible for a temporary ARRA premium reduction for up to fifteen months, or for the balance of the available period of continued coverage, if less. To help determine whether you can get the ARRA premium reduction you should read this notice and the attachments very carefully.

*Involuntary Termination of Employment between March 2, 2010 and March 31, 2010 or such later date as may be specified in Federal law*

If you think you meet the criteria for the premium reduction, and have elected or will elect to continue your coverage under New Jersey Continuation, complete the "Application for Treatment as an Assistance Eligible Individual" and mail it to your former employer. Your mailing to the former employer must also include the Employer Information and Verification Form. If you previously elected continuation as a result of the reduction in hours, that continuation coverage will remain in effect for the balance of the 18 months. If you either did not make a continuation election upon the reduction in hours or made an election then later terminated the continuation, you have an opportunity upon termination of employment to make an election for continuation. The coverage for such an election will be effective as of the first period of coverage on or after the involuntary termination of employment, but the 18-month period for continuation will be measured from the date coverage ended upon reduction in hours. While there will be a period where there was no coverage such lapse in coverage will not be counted against you for pre-existing conditions credit purposes. The premium reduction will last no more than 15 months. Such 15-month premium reduction period neither extends nor reduces the 18 months available for New Jersey Continuation.

If your former employer offers more than one medical plan option to active employees you may elect to continue coverage under the other medical plan option(s) provided the cost is the same or less than the cost for the plan you had when your coverage ended. Check with your former

employer regarding alternate options and the cost for such options. The election for the alternate plan must be noted on the New Jersey Continuation Election Form and the Form for Switching Plan Options must be attached

If you are newly electing continuation upon the termination of employment following the prior reduction in hours you must make the election for continuation within 30 days after receiving this package of information. You will be required to pay the first premium *within 30 days* of the date you make the election for New Jersey Continuation. Send all premium payments to your former employer who will add such payments to the premium being sent to us (the carrier) for the coverage for active employees. If you qualify for the premium reduction, the premium you must pay will be 35% of the cost for the New Jersey Continuation coverage. *[Specific premium information is enclosed.] [Carriers, if it is not enclosed, say how the former employee can get it]*

Mail these completed forms to your former employer.

- ✓ New Jersey Continuation Election Form (if you are electing continuation now)
- ✓ Form for Switching Options (if you are electing another option)
- ✓ Request for Treatment as an Assistance Eligible Individual
- ✓ Employer Information and Verification

If you have any questions concerning an election for New Jersey Continuation or the premium reduction, please contact *[carrier member services at phone]*

Sincerely,  
*[Carrier]*

## New Jersey Continuation Election Form

For persons who first experienced a reduction in hours followed by an involuntary termination of employment between March 2, 2010 and March 31, 2010 or such later date as may be specified in Federal law

**Instructions:**

This Election Form can ONLY be used to elect New Jersey Continuation in the event of in the event of a reduction in hours followed by an *involuntary* termination of employment occurring between March 2, 2010 and March 31, 2010 or such later date as may be specified in Federal law. For *all other* elections of New Jersey Continuation please consult the employer that provided the group coverage under which you were covered.

To elect to continue medical coverage under New Jersey Continuation, the terminated employee must complete the following form and mail it to the former employer. The completed election form must be postmarked *within 30 days* of the date you receive this package.

If medical coverage under New Jersey Continuation is already in effect, do not complete this election form again.

I elect to continue medical coverage for myself and all dependents listed in item II below.

**I. Terminated Employee Information**

Name: \_\_\_\_\_ SS# \_\_\_\_\_ First  
MI Last or other identifier

Address \_\_\_\_\_  
Street City State Zip Code

Dates: \_\_\_\_\_  
Reduction in hours Date Medical Coverage Ended as a result of the reduction

\_\_\_\_\_  
Termination of employment

Was the termination an involuntary termination of employment?  Yes  No

If No, do not submit this form.

**II. Dependent Information**

List all dependents who were covered under your former employer's medical plan on the date before your hours were reduced and who you wish to cover under New Jersey Continuation. *Note:* Dependent coverage can ONLY be continued if the former employee elects to continue coverage for him/herself.

Name	Date of Birth	Relationship To employee	SS# or other identifier
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**III. Plan Selection**

Check one

Same coverage that was in effect on the day before coverage ended or such other replacement coverage as is currently offered to active employees

Alternate coverage. You must complete the Form for Switching Plan Options

**IV. Signature**

\_\_\_\_\_  
Signature of Terminated Employee

\_\_\_\_\_  
Date