**Summary of the COBRA Premium Assistance**

**Provisions under the American Rescue Plan Act of 2021**

(not for use for Clients eligible for federal COBRA)

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 or state continuance (“mini-COBRA”) 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 state continuance qualifying event that is a reduction in hours or an involuntary termination of a covered employee’s employment;
* **MUST** elect mini-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. [[1]](#footnote-1)\*

**♦ IMPORTANT ♦**

◊ If you do not elect to receive the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance.

◊ If you elect mini-COBRA continuation coverage with premium assistance, and then become eligible for other Dental, Vision and/or Gap coverage(not including a Qualified Small Employer Health Reimbursement Arrangement, or a health flexible spending arrangement), or if you become eligible for Medicare, you MUST notify the plan 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 plan is due to reasonable cause and not due to willful neglect.

◊ Employers that don’t satisfy mini-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 mini-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®[[2]](#footnote-2), such as on HealthCare.gov, for any months that you are enrolled in mini-COBRA continuation coverage with or without the premium assistance.

For general information on your plan’s continuation coverage, contact your former employer or Sun Life at 800-247-6875. Please reference you are calling about the American Rescue Plan Act (ARP).

For specific information on your plan’s administration of the ARP premium assistance, contact your former employer or Sun Life at 800-247-6875. Please reference you are calling about the American Rescue Plan Act (ARP).

To notify Sun Life that you are no longer an Assistance Eligible Individual (AEI), email [group.premium.inquiries@sunlife.com](mailto:group.premium.inquiries@sunlife.com). If you have already paid continuance premium for any eligible period of time, Sun Life will refund any premium paid to your former employer. Please contact your former employer for a refund.

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)

**If you want to be considered for subsidized premiums for your dental, vision and/or GAP coverage, send the completed “Request for Treatment as an Assistance Eligible Individual” to your former employer.**

**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.”**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL** | |  |
| **PERSONAL INFORMATION** | | | |
| Name and mailing address of employee (list any dependents on additional pages of this form)  Click or tap here to enter name  Click or tap here to enter address  Click or tap here to enter address  Click or tap here to enter city, state, zip | | Telephone number Enter phone # | |
| E-mail address (optional)  Enter email address | |

|  |  |  |
| --- | --- | --- |
| **CURRENT COVERAGE INFORMATION**  Policy Number: Enter policy number(s)  Dental Prepaid Dental/Dental HMO Vision Gap | | |
|  | | |
| 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) mini-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 employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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. | | |
| FOR EMPLOYER OR PLAN 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 mini-COBRA coverage. |  | |
| 4. Other – Explain |  | |
| Signature of insurer Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type or print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | |

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

**Dependent A**

Name: Click or tap here to enter dependent name

Date of Birth: Click or tap here to enter dependent date of birth

Relationship: Click or tap here to enter dependent relationship to employee

(to employee)

SSN: Click or tap here to enter dependent SSN or other identifer

(or other identifier)

|  |  |
| --- | --- |
| 1. I elected (or am electing) mini-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 Click or tap to enter a date.

Type or print name Click or tap here to enter name

Relationship to employee Click or tap here to enter relationship to employee

**Dependent B**

Name: Click or tap here to enter dependent name

Date of Birth: Click or tap here to enter dependent date of birth

Relationship: Click or tap here to enter dependent relationship to employee

(to employee)

SSN: Click or tap here to enter dependent SSN or other identifer

(or other identifier)

|  |  |
| --- | --- |
| 1. I elected (or am electing) mini-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 Click or tap to enter a date.

Type or print name Click or tap here to enter name

Relationship to employee Click or tap here to enter relationship to employee

\* Please provide the same dependent information for additional dependents.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) or by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by SLOC in all states, except New York. Prepaid dental products are provided and administered by SLOC, and provided by prepaid dental companies affiliated with SLOC in certain states except New York. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (SLHIC) (Lansing, MI). Group Hospital Confinement Indemnity “Gap” insurance is underwritten by Fidelity Security Life Insurance Company (Kansas City, MO), and is administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

1. \* This restriction does not include coverage under a plan that provides only excepted benefits, a qualified small employer health reimbursement arrangement, or coverage under a health flexible spending arrangement. [↑](#footnote-ref-1)
2. Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services. [↑](#footnote-ref-2)