

New Jersey Continuation Election Form

For involuntary terminations of employment between September 1, 2008 and December 31, 2009

Instructions:

This Election Form can ONLY be used to elect New Jersey Continuation in the event of an *involuntary* termination of employment occurring between September 1, 2008 and December 31, 2009. 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 this notice was received.

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 December 31, 2009

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 December 31, 2009.

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 Employee Benefit Security Administration.

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 December 31, 2009, 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.

<i>[Insert Carrier Name]</i>	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	<i>[Insert Carrier Mailing Address]</i>
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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 December 31, 2009.	<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

<input type="checkbox"/> 1. Loss of employment was voluntary.
<input type="checkbox"/> 2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.
<input type="checkbox"/> 3. Individual did not elect continuation coverage.
<input type="checkbox"/> 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]

[Carrier mailing address]

Participant Notification

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.

If any dependents are also eligible, include their names below.

Insert date you became eligible: _____

I am eligible for Medicare.

Insert date you became eligible: _____

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:

_____	_____
_____	_____