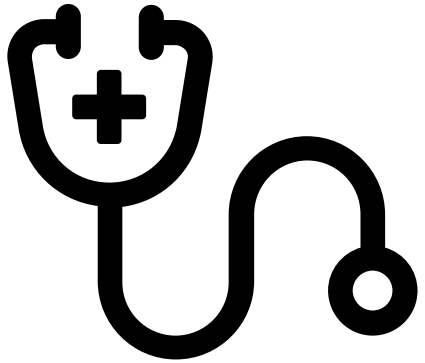
FREE HEALTH INSURANCE!

WE WON IT—
LET'S GO GET IT!

How to enroll in FREE COBRA



UNITEHERE!

TAKE BACK OUR HEALTH

Know your rights!

UNITE HERE workers fought hard to win FREE healthcare (COBRA) for 6 months, paid for by the U.S. government.

We're going to look at government forms that can be confusing. But you got this. We're right here with you.

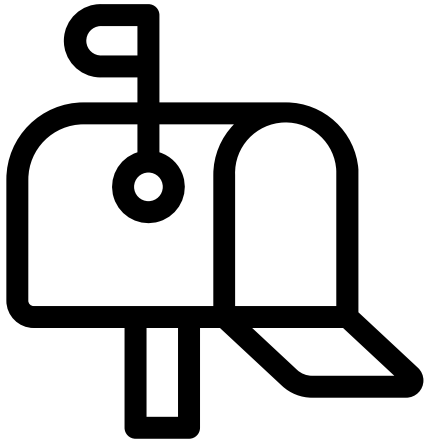
REMEMBER: if you're eligible, you have a RIGHT to this FREE HEALTHCARE

What is COBRA?

COBRA is a federal law that lets you continue your health insurance after you lose your job.

It’s usually expensive, but we won free COBRA through September 30 for millions of workers!

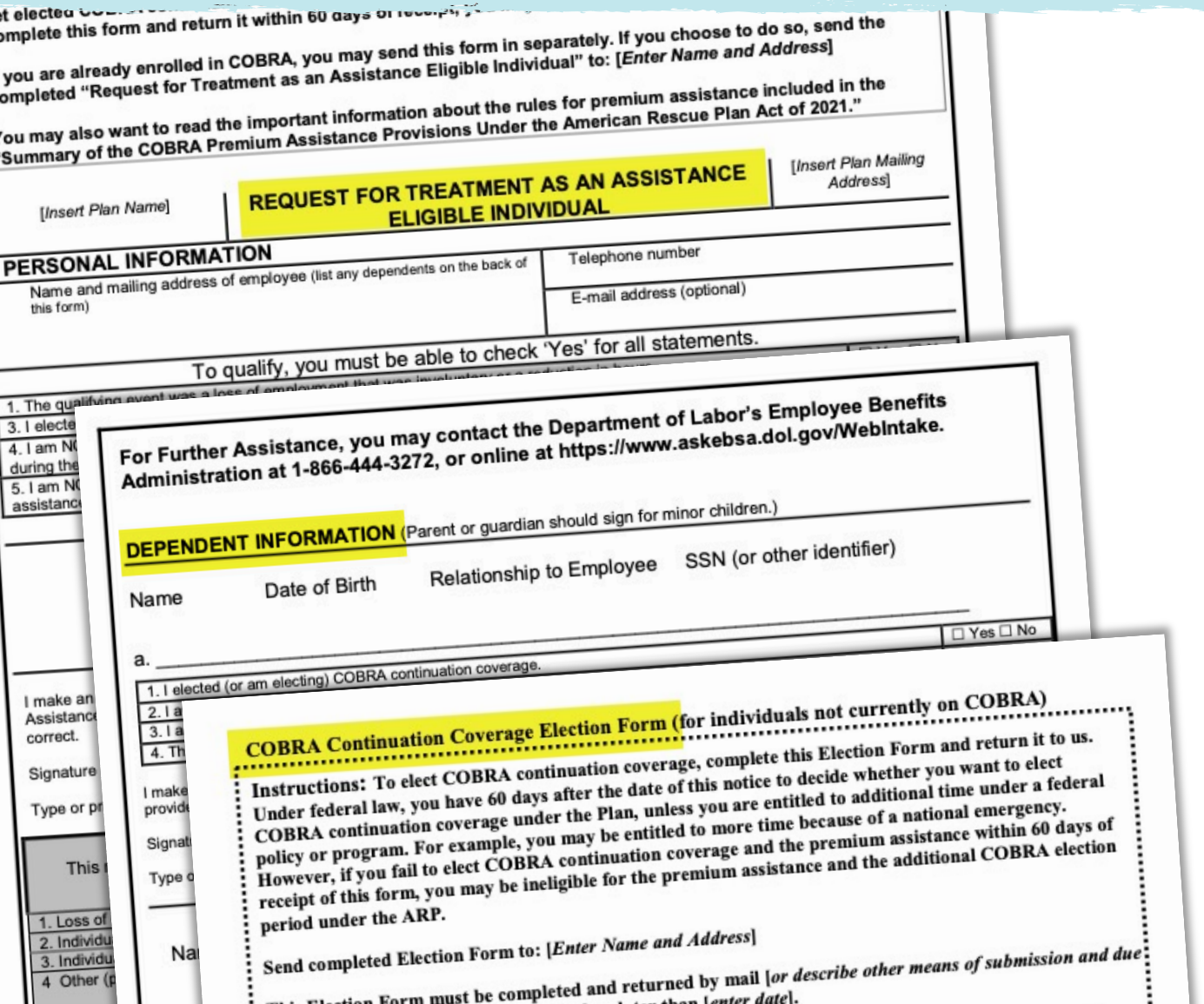
STEP 1: Check your mail!



Look for a big packet from the insurance you had before the pandemic.

If you don’t see the packet by May 31, call HR at your old job. The law says they must send it to you by then.

STEP 2: Look for 3 important forms



1. **"Request for Treatment as an Assistance Eligible Individual"**
2. **"Dependent Information"**
3. **"COBRA Continuation Coverage Notice** in Connection with Extended Election Periods"

Request for Treatment as an Assistance Eligible Individual

completed "Request for Treatment as an Assistance Eligible Individual" to: [*Enter Name and Address*]

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."

[*Insert Plan Name*]	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	[*Insert Plan Mailing Address*]

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number 702-123-4567
123 Fund Way Las Vegas, NV 89103	E-mail address (optional) johndoe@yahoo.com

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) 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: John Doe Date: 4/19/2021

Type or print name: John Doe Relationship to Member: myself

FOR EMPLOYER OR PLAN USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason below and return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Fill out all sections marked here in yellow.

You are eligible if you can answer "yes" to all 4 questions.

If you're not sure how to answer any of these questions, ask for help from your union.

How do I answer questions 3 & 4?

“I am NOT eligible for other group health plan coverage”

- Mark **YES** if you cannot be covered by your spouse’s health plan
- Mark **YES** if you cannot be covered by health insurance from a 2nd job
- Otherwise, mark **NO**. This means you are eligible for other group coverage and NOT eligible for free COBRA

“I am not eligible for Medicare”

- Mark **YES** if you are under 65
- Otherwise, mark **NO**. This means you are eligible for Medicare and NOT eligible for free COBRA

Dependent Information

Fill out the yellow section for each dependent who was covered by your pre-pandemic health plan before you lost it.

They have to answer "yes" to all 4 questions to be eligible.

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 Member	SSN
Maria Doe	12/1/1980	Spouse	234-56-7891
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 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: Maria Doe Date: 4/19/2021

Type or print name: Maria Doe Relationship to Member : Spouse

Name	Date of Birth	Relationship to Member	SSN
Joseph Doe	10/26/2005	Son	345-67-8910
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 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: John Doe Date: 4/19/2021

Type or print name: John Doe Relationship to Member : member

Name	Date of Birth	Relationship to Member	SSN

TIPS: Dependent Information

Sign and date the section for each dependent under age 18.

Dependents older than 18 sign the form themselves.

Need more space? Write on the back!

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 Member	SSN
Maria Doe	12/1/1980	Spouse	234-56-7891
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

COBRA Continuation

Complete and sign the form for yourself and each dependent you already listed on the Dependent Information form.

COBRA Continuation Coverage Election Form (for individuals not currently on COBRA)

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage and the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance and the additional COBRA election period under the ARP.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you don't submit a completed Election Form by the due date shown above, you may lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) listed below:

	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.	John Doe	04/19/1979	Self	123-45-6789
	[*Add if appropriate:* Coverage option elected: _____]			
b.	Maria Doe	12/01/1980	Spouse	234-56-7891
	[*Add if appropriate:* Coverage option elected: _____]			
c.	Joseph Doe	10/26/2005	Son	345-67-8910
	[*Add if appropriate:* Coverage option elected: _____]			

John Doe — Signature

04/19/2021 — Date

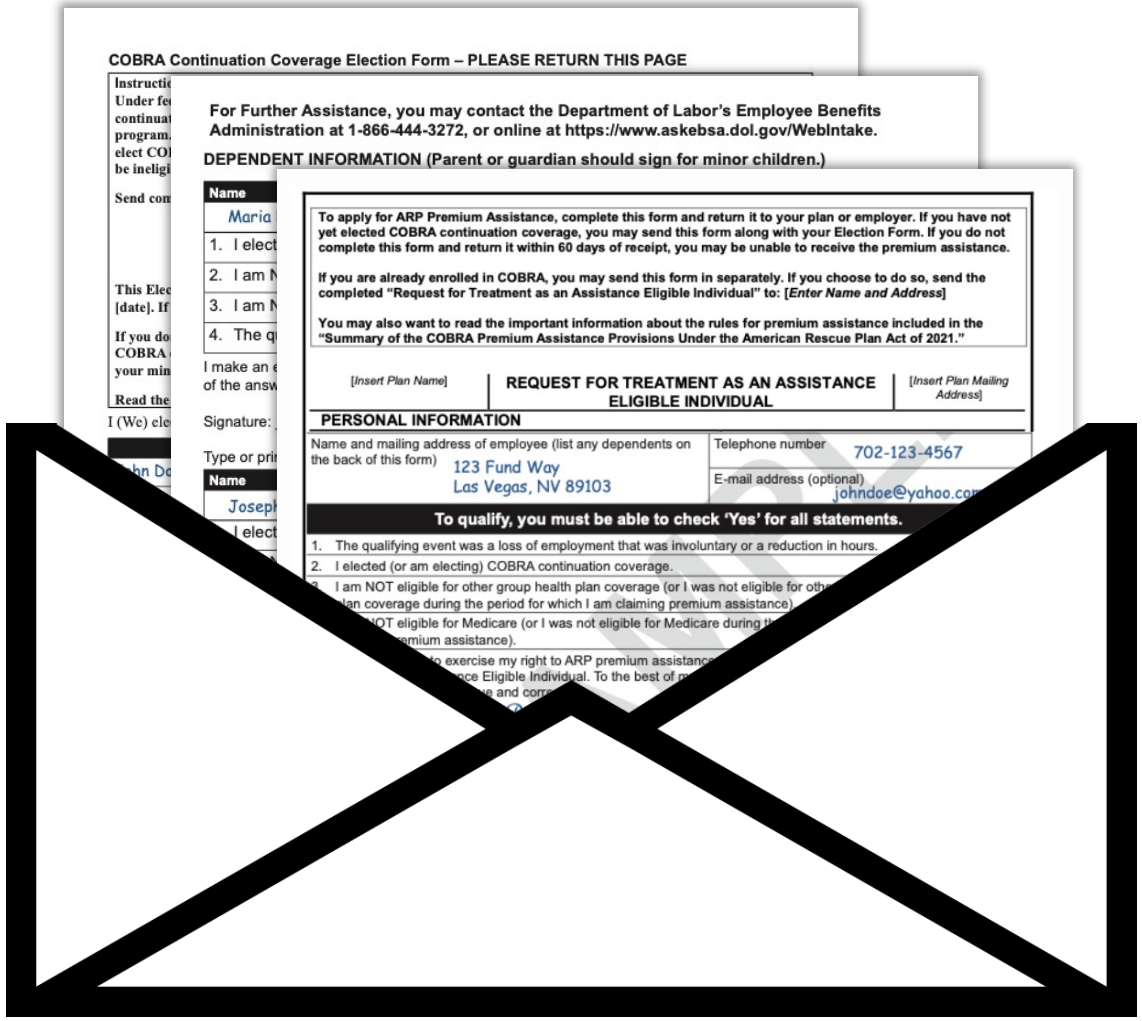
John Doe — Print Name

Self, Spouse, Parent — Relationship to individual(s) listed above

123 Fund Way

STEP 3: Send back your forms!

Follow the instructions in your packet



PARTICIPANT NOTIFICATION:
What do I do with this?

Keep this form in a safe place.

Only send this form if you become eligible for other health insurance before 9/30/21.

This form is designed for plans to distribute to COBRA qualified beneficiaries who are not paying premiums pursuant to ARP so they can notify the plan if they become eligible for other group health plan coverage, or Medicare.

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under the ARP.

Plan Name	**Participant Notification**	Plan Mailing Address

PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail address (optional)

PREMIUM ASSISTANCE 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_____	☐

TIPS: Participant Notification

Send this form if you become eligible for other health insurance before 9/30/21, even if you do not sign up for it or it's too expensive.

- This DOES include Medicare (for people over age 65)
- This DOES NOT include Medicaid (for low-income and disabled people)

If you become eligible for other health insurance but do not send this form, you may have to pay back the cost of your COBRA!

SWITCHING COBRA CONTINUATION COVERAGE

What do I do with this?

A few companies might give you different insurance options than what you had before.

If that happens, use this form to tell them what you want.

[Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.]

Form for Switching COBRA Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different than what you or the participating employee had on the last day of coverage, complete this form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.