

# ***FREE HEALTH INSURANCE!***

**WE WON IT—  
LET'S GO GET IT!**

**How to enroll in FREE COBRA**

***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**

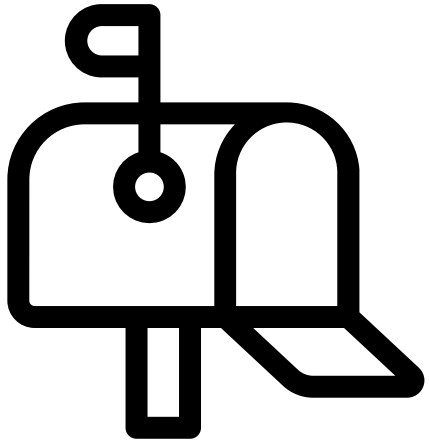
# What is COBRA?

**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 April 1 through September 30 for millions of workers!

# STEP 1: Check your mail!



**Look for a mailing from the Local 49  
SIHRTE Trust Fund (Sacramento  
Independent Hotel Restaurant and Tavern  
Employees Welfare Trust)**

***If you haven't gotten the mailing or may have misplaced it,  
call the Fund at #877-893-1500 and request enrollment forms!***

# STEP 2: Look for 3 important forms

...t elected COBRA...  
...complete this form and return it within 60 days of receipt...  
...you are already enrolled in COBRA, you may send this form in separately. If you choose to do so, send the 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."  
Sacramento Independent Hotel Restaurant and Tavern Employees Welfare Trust  
**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**  
P.O. Box 1306  
San Ramon, CA 94583  
**PERSONAL INFORMATION**  
Name and mailing address of employee (list any dependents on the back of this form) \_\_\_\_\_ Telephone number \_\_\_\_\_

1. "Request for Treatment as an Assistance Eligible Individual"

2. "Dependent Information"

3. "COBRA Continuation Coverage Notice in Connection with Extended Election Periods"

1. The qualifying event...  
3. I elected (or did not elect) COBRA continuation coverage...  
4. I am NOT eligible for COBRA continuation coverage during the period...  
5. I am NOT eligible for COBRA continuation coverage assistance...  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Type or print name \_\_\_\_\_ E-mail address \_\_\_\_\_  
Telephone number \_\_\_\_\_  
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 \_\_\_\_\_  
a. \_\_\_\_\_  
1. I elected COBRA continuation coverage...  
2. I am not electing COBRA continuation coverage...  
3. I am electing COBRA continuation coverage...  
4. The individual is not eligible for COBRA continuation coverage...  
I make a statement that the information provided is true and correct.  
Signature \_\_\_\_\_  
Type or print name \_\_\_\_\_  
This request for COBRA continuation coverage is being made by the individual who is the subject of the notice of termination of group health coverage.  
1. Loss of employment...  
2. Individual died...  
3. Individual disabled...  
4. Other (please specify) \_\_\_\_\_  
**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]  
Send completed Election Form to: SIHRTE Trust Fund, P.O. Box 1306, San Ramon, CA 94583 on and due date. If mailed, it must be post-marked no later than [enter date].  
If you do not complete and return this Election Form by the due date shown above, you may lose your right to COBRA continuation coverage before the due date, you



# Request for Treatment as an Assistance Eligible Individual

If you are already a member of COBRA, you may send this request to the administrator of the plan you are currently covered by.

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."

Sacramento Independent Hotel Restaurant and Tavern Employees Welfare Trust	<b>REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL</b>	P.O. Box 1306 San Ramon, CA 94583
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**PERSONAL INFORMATION**

Name and mailing address of employee (list any dependents on the back of this form) 123 Fund Way Las Vegas, NV 89103	Telephone number 702-123-4567
	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.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. I elected (or am electing) COBRA continuation coverage.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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 2<sup>nd</sup> 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 must be able to answer “yes” to all 4 questions to be eligible.

*NOTE: Dependents should answer Question 4 based on your employment, not theirs.*

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.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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
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# 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.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for Medicaid.			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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: SIHRTE Trust Fund, P.O. Box 1306, San Ramon, CA 94583

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	04/19/2021		
Signature	John Doe		Date	Self, Spouse, Parent
Print Name			Relationship to individual(s) listed above	
	123 Fund Way			

# STEP 3: Send back your forms!

Follow the  
instructions in  
your packet

COBRA Continuation Coverage Election Form – PLEASE RETURN THIS PAGE

Instructions:  
Under federal law, you have the right to continue your group health plan coverage if you or a dependent are eligible for COBRA continuation coverage. If you elect COBRA continuation coverage, you must pay the full premium for the coverage. If you do not elect COBRA continuation coverage, you will lose your group health plan coverage. If you are not eligible for COBRA continuation coverage, you will not be able to continue your group health plan coverage.

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: Maria

1. I elect COBRA continuation coverage.

2. I am not electing COBRA continuation coverage.

3. I am not electing COBRA continuation coverage.

4. The qualifying event was a loss of employment that was involuntary or a reduction in hours.

I make an election of the answer to the above questions.

Signature: \_\_\_\_\_

Type or print name: Joseph

To apply for ARP Premium Assistance, complete this form and return it to your plan or employer. If you have not yet elected COBRA continuation coverage, you may send this form along with your Election Form. If you do not complete this form and return it within 60 days of receipt, you may be unable to receive the premium assistance.

If you are already enrolled in COBRA, you may send this form in separately. If you choose to do so, send the 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."

Sacramento Independent Hotel Restaurant and Tavern Employees Welfare Trust P.O. Box 1306 San Ramon, CA 94583

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form): 123 Fund Way Las Vegas, NV 89103

Telephone number: 702-123-4567

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.

2. I elected (or am electing) COBRA continuation coverage.

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).

4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).

5. I am NOT eligible for Medicaid (or I was not eligible for Medicaid during the period for which I am claiming premium assistance).

6. I am NOT eligible for any other health plan coverage (or I was not eligible for any other health plan coverage during the period for which I am claiming premium assistance).

7. I am NOT eligible for any other health plan coverage (or I was not eligible for any other health plan coverage during the period for which I am claiming premium assistance).

8. I am NOT eligible for any other health plan coverage (or I was not eligible for any other health plan coverage during the period for which I am claiming premium assistance).

9. I am NOT eligible for any other health plan coverage (or I was not eligible for any other health plan coverage during the period for which I am claiming premium assistance).

10. I am NOT eligible for any other health plan coverage (or I was not eligible for any other health plan coverage during the period for which I am claiming premium assistance).

# PARTICIPANT NOTIFICATION:

## *What do I do with this?*

### WARNING!

If you are eligible for  
Free COBRA and  
want to enroll  
**DON'T FILL OUT THIS  
FORM!**  
It will cancel your  
enrollment.

*Keep it in a safe place and only  
send it in if you become eligible  
for other group health  
insurance or Medicare before  
9/30/21.*

<p>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.</p>		
<p>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.</p>		
<p>Sacramento Independent Hotel Restaurant and Tavern Employees Welfare Trust</p>	<p>Participant Notification</p>	<p>P.O. Box 1306 San Ramon, CA 94583</p>
<p><b>PERSONAL INFORMATION</b></p>		
<p>Name and mailing address</p>		<p>Telephone number</p>
		<p>E-mail address (optional)</p>
<p><b>PREMIUM ASSISTANCE INELIGIBILITY INFORMATION – Check one</b></p>		
<p>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 _____</p>		<p><input type="checkbox"/></p>

# TIPS: Participant Notification

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