



11971 Foundation Place
Rancho Cordova, CA 95670
ATTN: Cobra DP MS CA -903-02-02

Name
Address
City, ST Zip

Dear Health Net Member-

Please stop and read this packet in its entirety. This packet will include information on enrollment under Cal COBRA and the Premium Reduction Subsidy provided by the ARRA.

To ensure that your applications are processed in a timely manner please verify that you have included the following documents that are applicable.

For Subsidy Enrollment please return

- Cal Cobra enrollment form (page 4 & 5)
and
- Request for Treatment as an Assistance Eligible Individual (AEI) (Page 12-14)

Your subsidy will be effective on the **first of the month following the return of this application to Health Net.** Any over payment of premiums, if applicable, will be credited to future billings.

Continuation Coverage Election Notice

(For use where coverage is subject to Cal-COBRA continuation requirements during the period that begins with September 1, 2008 and ends May 12, 2009)

Date:

Dear: *[Identify the qualified beneficiary(ies), by name or status]*

This notice contains important information about your right to continue your health care coverage through Health Net (the Plan). Please read the information contained in this notice very carefully.

Cal-COBRA Premium Reduction

The federal American Recovery and Reinvestment Act of 2009 (ARRA) reduces the Cal-COBRA continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “Request for Treatment as an Assistance Eligible Individual” and return it with your completed Cal-COBRA Continuation Coverage Election Form.** Note, you may have dependents enrolled that qualify for Cal-COBRA coverage but do not qualify for premium reduction (examples include domestic partners, same-gender spouses and grandchildren).

Enrolling in Cal-COBRA Continuation Coverage

Certain individuals who previously declined Cal-COBRA Coverage (or who elected Cal-COBRA coverage and then later disenrolled) may be eligible for an additional opportunity to enroll in Cal-COBRA coverage with the nine-month premium reduction. To see if you are eligible to enroll during this additional election period, please see the page entitled “Additional Election Period.” If your election period has not expired and you may be eligible for premium assistance, your election period may also be extended.

To elect continuation coverage follow the instructions on the following pages, complete the enclosed Cal-COBRA Continuation Coverage Election Form and submit it to us within 60 days of the date of this notice. *

***If you are not eligible for the premium reduction and your original election period has expired,** you will not be able to elect continuation coverage during this additional election period.

***If you are not eligible for the premium reduction and your original election period *has not* expired,** you may still elect Cal-COBRA by completing the attached Cal-COBRA Continuation Coverage Election Form and submitting it to us. If you are unsure if your election period has expired, you may contact the health plan at the number listed below.

Each person who was validly enrolled on the group health plan may be entitled to elect continuation coverage, which will continue group health care coverage under the Cobra Plan for up to 36 months.

If eligible, your coverage will become effective on the first day of the month after you submit the election forms and you must pay all premiums due from that date forward. Your Cal-COBRA coverage will extend for a maximum of 36 months from the date of your original qualifying event. The ARRA subsidy, if applicable, provides a premium reduction for a maximum of 9 months.

Premium Information

Cal-COBRA continuation coverage usually costs 110% of the applicable group rate for which you and your dependents may be eligible. But if you qualify as an “Assistance Eligible Individual” this cost can be reduced to 35% of that amount for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Cal-COBRA Continuation Coverage Election Form. Note, you may have dependents enrolled that qualify for Cal-COBRA coverage but do not qualify for premium reduction (examples include domestic partners, same-gender spouses and grandchildren). In that case you may be required to pay the full portion of the dues/premiums attributable to that dependent. Contact Health Net at 800-977-2207 for further information. Shown below is the full amount of premium you would pay for Cal-COBRA coverage if you do not qualify for the premium reduction. You will also see how much you would pay if you are eligible to pay 35% of the total premium for nine months.

VERIFICATION OF ELIGIBILITY FOR PREMIUM REDUCTION

To qualify for the subsidy you must be able to show that your former employer involuntarily terminated you. If you have a document that shows that you were involuntarily terminated, you may submit that as verification you were terminated.

Health Net may also request verification from your former employer that you were involuntarily terminated once you submit your “Request for Treatment as an Assistance Eligible Individual” form. Your employer must respond within 10 calendar days from the date Health Net sends the request for verification. If you are denied treatment as an Assistance Eligible Individual you have the right have your denial reviewed by The Department of Health and Human Services.

Option to Change to A New Health Plan or Carrier

If you are eligible for the premium reduction, your former employer may also permit you to change the coverage option(s) for your Cal-COBRA continuation coverage to something different than what you had on the last day of employment. The premiums for the new coverage may not exceed the premiums for your original coverage. Contact your former employer for further information, including health plan options and premiums. If your former employer allows you to change your coverage you may use the attached “Election Form to Change to a New Health Plan.” **This form must be sent to your former employer within 90 days of the date of this notice.** If your employer grants the option to change to a new health plan, he or she must fill in the appropriate portions of the form and submit it to the new plan, along with any other necessary information.

IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE OR IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OF YOUR RIGHTS TO CONTINUATION COVERAGE, PLEASE CONTACT HEALTH NET AT 800-977-2207 OR THE TDD LINE AT 800-995-0852 FOR THE HEARING AND SPEECH IMPAIRED.

Notice of Right to Elect
Cal-COBRA Continuation Coverage

NAME SAMPLE
ADDRESS1
ADDRESS2

Qualifying Event: Loss of prior coverage
Date of Qualifying Event: Sample QED
Election Period Expiration Date: 60 days after date of mailing

Employee: NAME SAMPLE
Employer: EMPLOYER SAMPLE

Qualified Beneficiaries Eligible: NAME SAMPLE
SPOUSE SAMPLE
DAUGHTER SAMPLE
SON SAMPLE

Dear Valued Health Net Member,

As a result of the Qualifying Event identified above your coverage under your employer group benefit plan has been or will be terminated. Under the California Continuation Benefits Replacement Act, or Cal-COBRA, you and/or your covered dependents are entitled to Continuation Coverage under your Health Net group benefit plan.

To retain your right to Continuation Coverage, the attached Election Form must be completed (including signature) and returned to Health Net prior to your Election Period Expiration Date of «ElectionexpDate». Failure to return the Election Form to Health Net will result in the loss of your right to Continuation Coverage with no possibility of reinstatement.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

If you choose to elect Continuation Coverage, you must remit all required premiums to Health Net within 45 days of your election. Failure to remit these premiums will result in the loss of your right to Continuation Coverage with no possibility of reinstatement. Health Net recommends that you include your first premium payment with your election form to prevent disqualification for Continuation Coverage.

President Obama signed into law on February 17, 2009 the federal American Recovery and Reinvestment Act of 2009 (ARRA), which reduces the Cal-COBRA continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Application for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “American Recovery and Reinvestment Act Application/Attestation Form” and return it with your completed Election Form.** You may have dependents enrolled that qualify for Cal-COBRA coverage but do not qualify for premium reduction (examples include domestic partners, same gender spouses and grandchildren).

Cal-COBRA CONTINUATION COVERAGE ELECTION FORM

Premium Changes

Health Net can change the premium required for Continuation Coverage for the following reasons:

#	Reason for Premium Change
1	The member may have an increase in premium amount due to qualifying for a disability extension of coverage.
2	If Health Net was previously requiring payment of less than the maximum amount allowed by state law.
3	A benefit level change or qualified beneficiary change is made during the employer group's open enrollment period.
4	The employer group for which your Continuation Coverage is affiliated undergoes a rate change at contract renewal.
5	Any qualified beneficiary receiving a subsidized premium reduction through ARRA the premiums will revert to 100% of COBRA premium at the end of the eligibility period. The subsidy is for a maximum of 9 months

Termination of Coverage

Your Continuation Coverage may be terminated before the expiration of the 36 months for the following reasons:

#	Reason
1	The qualified beneficiary requests termination of Continuation Coverage. In the event the qualified beneficiary(ies) is less than 18 years of age, the parent or guardian must request termination. Termination requests must be received in writing within 30 days of the requested termination date. All terminations will be effective the last day of the coverage month.
2	Your employer or any purchaser of your employer ceases to provide any group benefit plan to its employees or your employer obtains coverage from another plan*; * In the event that the employer terminates a group benefit plan during your Continuation Coverage period to go to a new plan, you will be given the opportunity to continue coverage under the subsequent plan for the remainder of your coverage period.
3	Your employer's health plan contract is terminated for non-payment of premiums;
4	Failure to make timely payments in accordance with the terms of your Health Net contract;
5	You are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that does not impose any exclusion or limitation with respect to any preexisting condition you may have;
6	You are entitled or become entitled* to Medicare; (*If you are 65 or over, if you have received or have applied for Social Security, or qualify for Social Security at an early age due to a disabling condition you are considered to be entitled to Medicare.)
7	You are eligible for or become eligible for coverage under CAL-COBRA pursuant to the Internal Revenue Code or the Employee Retirement Income Security Act, or pursuant to the Public Health Service Act;
8	Continuation Coverage shall terminate if you fail to comply with the requirements to enroll in, and make payment of premiums to, any new group benefit plan within 30 days of receiving notice of termination of your prior group benefit plan.

DEPARTMENT OF HEALTH SERVICES

714/744 P Street
 P.O. BOX 1287
 SACRAMENTO, CA 95812-1287

**NOTICE TO TERMINATING EMPLOYEES**

The California Department of Health Services will pay health insurance premiums for certain persons who are losing employment and have a high cost medical condition. In order to qualify for the Health Insurance Premium Payment (HIPP) Program, you must meet ALL of the following conditions:

- 1) You must currently be on Medi-Cal.
- 2) Your Medi-Cal Share of Cost, if any, must be \$200 or less.
- 3) You must have an expensive medical condition. The average monthly savings to Medi-Cal from your health insurance must be at least twice the monthly insurance premiums. If you have a Medi-Cal Share of Cost, that amount will be subtracted.
- 4) Your monthly health care costs to determine if paying the premiums is cost-effective.
- 5) You must have a current health insurance policy, COBRA or CAL-COBRA continuation policy, or a COBRA conversion policy in effect or available at the time of application.
- 6) Your health insurance policy must cover your high cost medical condition.
- 7) Your application must be completed and returned in time for the State of California to process your application and pay your premium.
- 8) Your health insurance policy must not be issued through the California Managed Risk Medical Insurance Board.
- 9) You must not be enrolled in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care Program, or the County Medical Services Program (CMSP).

NOTE: If an absent parent has been ordered by the court to provide your health insurance, you will not be eligible for the HIPP Program.

For more information you may call this toll free number, 1-800-952-5294, and follow the recorded instructions.

FOR PERSONS DISABLED BY HIV/AIDS

Under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, persons unable to work because of disability due to HIV/AIDS and are losing their private health insurance may qualify for premium payment assistance through the CARE Health Insurance Premium Payment (CARE/HIPP) program for up to 12 months (in some cases clients may be eligible for extended program coverage) if they meet the following criteria:

1. Have applied for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), State Disability Insurance (SDI), or other disability programs;
2. Are currently covered by a health insurance plan (COBRA, Ca-COBRA individual or group), which includes outpatient prescription drug coverage and HIV-related treatment services;
3. Are not currently on the AIDS Drug Assistance Program (ADAP) for any outpatient prescription drug that can be covered by private insurance.
4. Have a total monthly income of no more than 250 percent of the current federal poverty level and;
5. Will be eligible for the Medi-Cal/HIPP or a County Organized Health System (COHS) HIPP program by the end of the 12-month coverage period (some clients may be eligible for extended program coverage).

For additional information on CARE/HIPP, you may call:

AIDS Hotline
 1-800-367-2437 (English/Spanish)
 (4/98) Labor Code § 2807(a) & (b)

Southern California AIDS Hotline
 1-800-922-2437 (English)
 1-800-922-2438 (Multi-Language)

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

IMPORTANT INFORMATION ABOUT YOUR CAL-COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

State law requires that most group health coverage provided by employers with less than 20 employees (including this coverage) give employees and their families the opportunity to continue their coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse or domestic partner, and the dependent children of the covered employee, spouse or domestic partner.

Continuation coverage is the same coverage that the Plan gives to other enrollees under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including the right to change plans at open enrollment.

How long will continuation coverage last? As long as you continue to meet the other qualification requirements, coverage can last for up to 36 months from the date of your original qualifying event. The ARRA subsidy, if applicable, provides a premium reduction for a maximum of 9 months

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Cal-COBRA Continuation Coverage Election Form and furnish it according to the directions on the form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost? Cal-COBRA generally costs 110% of the amount charged for the coverage for active employees or dependents under the group plan. In the case of a qualified beneficiary who is determined to be disabled under the Medicare statutes the cost is 150% of the group rate after the first 18 months of Cal-COBRA continuation coverage.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 % of the continuation coverage premium otherwise due to the issuer. This premium reduction is available for up to nine months. If your Cal-COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount

to continue your Cal-COBRA continuation coverage. See the attached “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” for more details, restrictions, and obligations as well as the form necessary to establish eligibility. Note, you may have dependents enrolled that qualify for Cal-COBRA coverage but do not qualify for premium reduction (examples include domestic partners, same gender spouses and grandchildren). In that case you may be required to pay the full portion of the dues/premiums attributable to that dependent. Contact Health Net at 800-977-2207 for further information.

When and how must payment for continuation coverage be made?

The first payment must be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to Health Net within 45 days of the date the qualified beneficiary provided written notice to Health Net of the election to continue coverage in order for coverage to be continued. The first payment must equal an amount sufficient to pay any required premiums and all premiums due. Failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving Cal-COBRA continuation coverage pursuant to this article.

You may contact Health Net to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Your payment(s) for continuation coverage should be sent to Health Net as directed on your billing statement.

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available in your Evidence of Coverage or by contacting Health Net.

If you have any questions concerning the information in this notice, your rights to coverage, or your rights under state law, you should contact Health Net at the telephone number noted on your ID card.

Keep Your Plan Informed of Address Changes

In order to protect your and your family’s rights, you should keep Health Net informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to Health Net.

ADDITIONAL ELECTION PERIOD

Please read carefully if either of the following applies to you:

If you experienced a loss of group coverage at some time from September 1, 2008 through March 18, 2009 and either chose not to elect Cal-COBRA continuation coverage at that time OR elected Cal-COBRA but subsequently discontinued that coverage.

If your loss of health coverage was due to an involuntary termination of employment you may be eligible for a second Cal-COBRA election opportunity and the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.”

This Additional Election period may also be available to any dependent who was validly enrolled on the group health plan and for whom Cal-COBRA continuation coverage was not elected or was discontinued. Note, however, certain dependents who may be enrolled on Cal-COBRA coverage do not qualify for the premium reduction and, therefore, do not qualify for the special election (examples include domestic partners, same-gender spouses and grandchildren).

Effective Date of Coverage

If eligible for premium assistance under ARRA and if the involuntary termination occurred prior to February 17, 2009, your coverage will become effective on the first day of the month after you submit the election forms and you must pay all premiums due from that date forward. Your Cal-COBRA coverage will extend for a maximum of 36 months from the date of your original qualifying event. The ARRA subsidy, if applicable, provides a premium reduction for a maximum of 9 months.

The first day of the month following the date you elect Cal-COBRA coverage using the attached election forms

You will only have to pay for premiums starting with the month you elect coverage. Health Net will not pay for any of your health care costs that occurred between the date of your involuntary termination and the first day of the month after you elect Cal-COBRA coverage. If you choose to elect Cal-COBRA on a going forward basis, you may not be eligible for guaranteed health insurance coverage under HIPAA after your Cal-COBRA expires. If you have questions, please contact Health Net at 800-977-2207.

To apply for this special additional election, all necessary forms must be submitted to Health Net within sixty (60) days.

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an Assistance Eligible Individual and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- 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 successor employer or a spouse’s employer.*

.. IMPORTANT ..

- ? If, after you elect Cal-COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ? Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ? The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding continuation coverage you can contact Health Net at the telephone number noted on your ID card.

For specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, contact Health Net.

If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for AARA Premium Reduction, complete this form and return it to us along with your Cal-COBRA Continuation Coverage Election Form.

Please return to:

Health Net, 11971 Foundation Place, Rancho Cordova, CA 95670 Attn: Cobra DP Unit, Mail Stop CA-903-02-05

You may also want to read the important information about your rights included in the “Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA”.

Health Net of California Membership Dept. Mail Stop CA-903-02-05	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	11971 Foundation Pl Rancho Cordova, Ca 95670
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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):

Subscriber SSN:

Health Net Group Number:

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

***If you checked NO for statement 3, you may still be eligible. See below for more information.**

ADDITIONAL ELECTION PERIOD

If your Cal-COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, Cal-COBRA continuation coverage **OR** you elected but subsequently discontinued Cal-COBRA, you may have the right to an additional 60-day election period. See the additional “Additional Election Period” notice included with these materials. You **MUST** complete and return a new “Cal-COBRA Continuation Coverage Election Form” along with the Request for “Treatment as an Assistance Eligible Individual Form”.

I make an election to exercise my right to the ARRA Premium Reduction. 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: _____

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

Name: _____ Date of Birth: _____

Relationship to Employee: _____ SSN (or other identifier): _____

1. I elected (or am electing) Cal-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. I am NOT a Domestic Partner of the subscriber. Yes No

5. I am NOT a same-sex spouse of the subscriber. Yes No

6. I am NOT a grandchild of the subscriber. Yes No

I make an election to exercise my right to the ARRA Premium Reduction. 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: _____

Name: _____ Date of Birth: _____

Relationship to Employee: _____ SSN (or other identifier): _____

1. I elected (or am electing) Cal-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. I am NOT a Domestic Partner of the subscriber. Yes No

5. I am NOT a same-sex spouse of the subscriber. Yes No

6. I am NOT a grandchild of the subscriber. Yes No

I make an election to exercise my right to the ARRA Premium Reduction. 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 ISSUER 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Individual did not elect continuation coverage.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Other (please explain)	<input type="checkbox"/>

***If you checked number 3, was the individual eligible for, and given, the Additional Election Period described above?**

Yes/No _____

Signature of party responsible for continuation coverage administration for the Plan:

_____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____

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

Health Net
Attn: Cobra DP Unit

**PARTICIPANT NOTIFICATION OF
INELIGIBILITY**

11971 Foundation Place
Rancho Cordova, CA 95670
MS CA-903-02-05

PERSONAL INFORMATION

Name and mailing address:	Telephone number:
Social Security 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 for other coverage, include their names below. Insert date you became eligible: _____	<input type="checkbox"/>
I am eligible for Medicare. Insert date you became eligible for other coverage: _____	<input type="checkbox"/>

IMPORTANT

If you provide false eligibility information to your carrier or 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 or 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:

_____	_____
_____	_____

ELECTION FORM FOR CHANGING TO A NEW HEALTH PLAN

This form must be submitted to your former employer. If your employer chooses to allow qualified individuals to change health plans, he or she must complete the appropriate portions of this form and forward it, and any other necessary information, to the new health plan.

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form):	Telephone number:
	E-mail address (optional):
	Social Security Number:
Name and mailing address of former employer:	Telephone number:
	E-mail address (optional):

Name and Member ID of current health plan:

To qualify for the Option to Change to a New Health Plan, you must be able to check 'Yes' for all statements.

1. I am currently enrolled in Cal-COBRA with my current health as named above or I am electing Cal-COBRA coverage under this notice and changing to a new health plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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
4. The former employer allows a change in coverage to a different health plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I am exercising my right to enroll in this health plan's Cal-COBRA continuation coverage as permitted by my employer. 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 EMPLOYER USE ONLY
EMPLOYER - COMPLETE THIS SECTION AND SUBMIT TO THE HEALTH PLAN YOU HAVE
APPROVED FOR ALTERNATIVE COVERAGE

Name and address of alternative plan:	Phone number:
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1. The applicant was validly enrolled in group health coverage at the time of their qualifying event.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The former employer allows a change in coverage to a different health plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. The premiums for new coverage do not exceed the premiums for the enrollee's original coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of the former employer or party authorized to act for the employer:
 _____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____

FOR PLAN OR 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The individual's employer does not permit a change in coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Other (please explain):	<input type="checkbox"/>

Signature of plan, carrier, or other party responsible for administration of the Cal-COBRA coverage:

_____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____