

To apply for the ARRA Premium Reduction, please complete this form (including all dependent information), then return it to the AFTRA Health Fund (the Fund) within 60 days at:

PO Box 13681
Newark, NJ 07188-3681

Read important information about your rights in the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended."

AFTRA Health Fund

**REQUEST FOR TREATMENT AS AN ASSISTANCE
ELIGIBLE INDIVIDUAL**

PO Box 13681
Newark, NJ
07188-3681

PERSONAL INFORMATION

Name and Mailing Address of Participant (indicate if mailing address is for a business manager, agent or other authorized representative).

Telephone Number

E-mail Address (optional)

The last day I worked for a Contributing Employer¹ to the AFTRA Health Fund was _____. The name, address and contact person information of the last Contributing Employer I worked for are:

(Month/Day/Year)

Employer Name: _____

Employer Address: _____

Employer Contact Person and Phone 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 March 31 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for or actually enrolled in other group health plan coverage (or I was not eligible for or enrolled in other group health plan coverage during the period for which I am claiming a reduced premium) either through my own employment, a spouse or another family member.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for or enrolled in Medicare (or I was not eligible for or enrolled in Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹ Contributing Employer is the AFTRA Health & Retirement Funds (AFTRA H&R) and any other employer who is required and permitted under the Trust Agreement to contribute to the AFTRA Health Fund (the Fund) under the terms of a collective bargaining agreement with AFTRA or a written agreement with the Fund.

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

Name _____ Date of Birth _____ Relationship to Participant _____ Social Security Number _____
a. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for or enrolled in other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for or enrolled in Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Participant _____

Name _____ Date of Birth _____ Relationship to Participant _____ Social Security Number _____
b. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for or enrolled in other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for or enrolled in Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Participant _____

Name _____ Date of Birth _____ Relationship to Participant _____ Social Security Number _____
c. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for or enrolled in other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for or enrolled in Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Participant _____