

To apply for the Stimulus Bill subsidy, complete this form and return it to your former employer.



**PREMIUM SUBSIDY REQUEST FORM
for Oregon Continuation Coverage**

Providence Health
Plans
P.O. Box 5728
Portland, OR 97228-
5728

EMPLOYEE INFORMATION

Name and mailing address of employee: (list any dependents below)	Telephone number:
	E-mail address: (optional)

To qualify, you must be able to check "Yes" for all statements.

1. I became ineligible for group coverage due to a loss of employment that was involuntary or due to a reduction in hours between Sept. 1, 2008, and March 31, 2010, that was followed by an involuntary loss of employment March 2 through 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after Sept. 1, 2008, and on or before March 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) Oregon 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 elect to exercise my right to the Stimulus Bill subsidy. 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)

a. _____

1. I elected (or am electing) Oregon continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT a domestic partner or the dependent of a domestic partner.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the Stimulus Bill 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)

b. _____

1. I elected (or am electing) Oregon continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT a domestic partner or the dependent of a domestic partner.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the Stimulus Bill 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) _____

C. _____

1. I elected (or am electing) state continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT a domestic partner or the dependent of a domestic partner.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the Stimulus Bill 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: _____

Subsidies of continuation premium are available if you are an assistance-eligible individual under the federal American Recovery and Reinvestment Act (ARRA), commonly known as the Stimulus Bill.

FOR EMPLOYER USE ONLY

Please check the box to verify if the following are true. If "Yes" boxes are checked for questions 1 and 2, then send to Providence Health Plan. If any of the "No" boxes are checked, then return this form to the applicant and inform them that the subsidy request cannot be approved. The applicant has a right to appeal a denial as specified below.

1. Loss of employment was involuntary.	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. The involuntary loss occurred between Sept. 1, 2008, and March 31, 2010.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. If applicable, the loss of coverage was due to a reduction in hours between Sept. 1, 2008, and March 31, 2010, that was followed by an involuntary loss of employment March 2 through 31, 2010.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Signature of authorized representative of the employer:

_____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____

FOR PROVIDENCE HEALTH PLAN USE ONLYThis application is: Approved Denied Approved for some/denied for others (explain in #4 below)

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between Sept. 1, 2008, and March 31, 2010.	<input type="checkbox"/>
3. The reduction in hours did not occur between Sept. 1, 2008, and March 31, 2010.	<input type="checkbox"/>
4. Individual did not elect Oregon continuation coverage.	<input type="checkbox"/>
5. Other (please explain)	<input type="checkbox"/>

Signature of authorized representative of Providence Health Plan:

_____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____

Right to appeal: If the application is denied the applicant may appeal the denial. The applicant must contact the Center for Medicare and Medicaid Services (CMS), at NewCobraRights@cms.hhs.gov to initiate their appeal.