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American Rescue Plan Act 2021 COBRA Subsidy Notice of Assistance Eligible Individuals

Submit this form as soon as possible, but no later than July 30, 2021 via email to: COBRA-ARPA@calchoice.com or fax to (714) 908-3549

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- Complete the table below listing all Assistance Eligible Individuals (AEI) who have opted-in for the COBRA subsidy. A COBRA Election Form is required for AEIs not currently enrolled on COBRA.
- Assistance Eligible Individuals are defined as all COBRA/Cal-COBRA qualified participants (and their families) who have been involuntarily terminated by their employer (other than by reason of such employee's gross misconduct) or have had the employee's hours reduced to a level below health benefit eligibility, between November 1, 2019 and August 31, 2021, and who have elected COBRA continuation coverage (including the COBRA members who elect during the 2nd Special COBRA Election period). Individuals who have voluntarily terminated their own employment are not considered AEIs.
- Individuals who have been involuntarily terminated by their employer (other than by reason of such employee's gross misconduct) or have had the employee's hours reduced to a level below health benefit eligibility, between November 1, 2019 and August 31, 2021, but do not have COBRA continuation coverage in effect as of April 1, 2021, but who would be an Assistance Eligible Individual if such election were so in effect, or who elected COBRA continuation coverage and discontinued from such coverage before April 1, 2021, must be notified by May 31, 2021, of their right to elect COBRA continuation coverage. This special election is an extension of the original election period but does not extend the original COBRA eligibility period.
- An AEI eligible beneficiary must already have elected Cal-COBRA or be within their election period to enroll during the premium-subsidy period of April 1, 2021 to September 30, 2021, even if the triggering/qualifying event occurs during the subsidy period itself.
- A completed Employee Termination Notification form is required for any employees that have terminated employment but continue to appear active on your group's invoice. **Group Name** Group #

COBRA (Federal) AEIs Employee Name Last 4 Digits of SSN Last Day of Coverage (MM/DD/YYYY)		
Employee Name	Last 4 Digits of SSN	Last Day of Coverage (MM/DD/YYYY)

My signature below indicates I have verified the member(s) listed are AEIs that have opted-in for the COBRA subsidy. As an authorized group contact, I understand COBRA premiums will be added to the group's invoice, and the group will be responsible for the member's COBRA premiums for up to 6 months from April 1, 2021 to the end of their COBRA eligibility period or they become eligible for other group health coverage or Medicare.

Authorized Group Contact Signature Print Name Date (MM/DD/YYYY) 27167

Additional entries, if needed, can be entered on next page.

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