AEI 2021 Subsidy Eligibility Attestation Form

The American Rescue Plan Act of 2021 (ARPA), enacted on March 11, 2021, subsidizes the full COBRA premium for "Assistance Eligible Individuals" for periods of coverage from April 1, 2021 through September 30, 2021.

Your employer requires that each of its COBRA Qualified Beneficiaries who are eligible for treatment as an AEI complete and return this Attestation of Eligibility form for the AEI Subsidy in order for the AEI Subsidy to be applied. Your AEI subsidy will not be applied until you have completed and returned this form.

If you do not complete and return this form within 60 days of receipt, you may be ineligible for premium assistance.

To qualify, every individual named on this form must meet ALL of the following requirements for treatment as an Assistance Eligible Individual (AEI):

1. The COBRA qualifying event was a loss of employment that was involuntary or a reduction of hours.
2. You elected (or are electing) COBRA continuation coverage.
3. You are NOT eligible* for other group health plan coverage such as a plan sponsored by a new employer or a spouse's employer (or you were not eligible for other group health plan coverage during the period for which you are claiming premium assistance). *Eligibility for other coverage is determined regardless of whether you take or decline the other coverage.
4. You are NOT eligible for Medicare (or you were not eligible for Medicare during the period for which you are claiming premium assistance).

Please read carefully the definition of an Assistance Eligible Individual contained in the "Summary of the COBRA Premium Assistance" section in this letter. If you believe that you are eligible for treatment as an AEI and eligible for the AEI Subsidy, please complete this Attestation of Eligibility Form and return it to us promptly with your Election Form, or, if you have already elected COBRA, to the following address:

ASI COBRA
PO Box 657
Columbia, MO 65205-0657

If you have questions about COBRA, the ARPA, premium reduction, or this Attestation of Eligibility Form, please contact our Customer Service Department at (877) 388-8331 during business hours.

[ ] **Check here to certify:** I have read this form and the notice of my rights under the ARPA. I hereby attest that I meet the requirements for treatment as an Assistance Eligible Individual. I further affirm that I am not now eligible for coverage under another Group Health Plan or Medicare, and I understand that if I become eligible for coverage under another Group Health Plan or Medicare that my eligibility for premium assistance under the ARPA will end and I must promptly notify my Plan Administrator. I affirm that I have elected or am electing COBRA continuation coverage. I understand that failing to notify the Plan Administrator when I become eligible for other group health plan coverage or Medicare or providing false or misleading information on this form to receive COBRA premium assistance may subject me to a penalty of $250 (or if the failure is fraudulent, the greater of $250 or 110% of the premium assistance provided after termination of eligibility).

Signature _____ **Date** _____

Print Name _____

Mailing Address _____

Former Employer _____

List Qualified Dependents:

Name _____
Name _____
Name _____
Name _____
Name _____
Name _____
Name _____
Name _____
Name _____