



Mini-COBRA Premium Subsidy Attestation and Verification Form

To be completed and submitted by the employer.

This form is only to be used by employers subject to state Mini-COBRA (2-19 employees).

Employer Group Name: _____

Employer Group #: _____ Tax ID #: _____

I certify that the employer group named above is subject to the Massachusetts mini-COBRA law (M.G.L. ch. 176J §9), not to federal COBRA, and that the employee listed below was involuntarily terminated on or after September 1, 2008, and before May 31, 2010. The employee and/or dependents listed below are Assistance Eligible Individuals (AEIs) and qualify for the 65% COBRA premium subsidy under the American Recovery and Reinvestment Act of 2009 (ARRA). The AEI's loss of employment was involuntary and they are not eligible for other group health plan coverage or Medicare at this time. I understand that domestic partners/ same-sex spouses and their dependents are not eligible for the subsidy.

Subscriber / dependents electing the 65% subsidy

Name of AEI: _____

SSN of AEI: _____ FCHP ID #: _____

Date of termination: _____

Below, please list the names of the AEI's eligible dependents who are participating in the COBRA subsidy. Include the names and their relationship to the AEI for all dependents. (e.g. spouse, ex-spouse, child, etc.)

| Name | Relationship | SSN |
|----------|--------------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

Continuation of coverage (COC) date: _____

Subsidy date requested (2/17/09 earliest date): _____

COC Premium charged to employee: _____

COC Premium billed by FCHP: _____

Subsidy amount requested: _____

You are required to inform Fallon Community Health Plan if the above individual notifies you of their eligibility for other health plan coverage or Medicare (regardless of whether or not they choose to enroll in that coverage). You are also required to notify FCHP when the individual's maximum COBRA coverage period has ended.

All of the information on this form is true and correct to the best of my knowledge and belief.

Signature Date

Print name Title

** In the event of a premium rate change, please submit a new attestation form reflecting the change in the subsidy amount.*