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 is eligible for COBRA during the period on or after April 1, 2021 due to an involuntary termination or a reduction in hours. The employee and/or dependents listed below have elected COBRA, are Assistance Eligible Individuals (AEIs) under the American Rescue Plan Act of 2021 (ARPA) and qualify for the COBRA premium subsidy under ARPA. The AEI's loss of coverage was involuntary and they are not eligible for other group health plan coverage or Medicare at this time. I understand that domestic partners and their dependents are not eligible for the subsidy.

Subscriber / dependents electing the subsidy

Name of AEI: _____

SSN of AEI: _____ Fallon Health 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.			

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Continuation of coverage (COC) date: _____

Subsidy date requested (4/1/2021 earliest date): _____

Premium billed by Fallon Health: _____

Subsidy amount requested/charged to employee: _____

You are required to inform Fallon Health 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 Fallon Health 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.*