

To apply for ARRA Premium Reduction, complete this form, have it validated by your former agency and return it to the Plan. Follow instructions attached to this form. If you are not currently enrolled in COBRA see "Additional Election Period" below.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions under ARRA."

DC 37 Benefits Fund
Attention: EEU Department,
8th fl.

**REQUEST FOR TREATMENT AS AN ASSISTANCE
ELIGIBLE INDIVIDUAL**

125 Barclay Street
New York, New York
10007

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

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

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. The loss of employment was involuntary. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I elected (or am electing) COBRA 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 |

*If you checked NO for statement 3, you may still be eligible. See below for more information.

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage OR you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. If you now wish to enroll you must complete a new COBRA application included in this package.

I make an election to exercise my right to the ARRA 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 ➤ _____

FOR EMPLOYER USE ONLY

This application is: Approved Denied

Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

- | | |
|----------------------------------------------------------------------------------------|--------------------------|
| 1. Loss of employment was voluntary. | <input type="checkbox"/> |
| 2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009. | <input type="checkbox"/> |
| 3. Other (please explain) | <input type="checkbox"/> |

I certify that this information is true and correct

Signature of Agency Authorized Representative _____

Date _____

Type or print name _____

Telephone number _____ E-mail address _____

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) COBRA 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

I make an election to exercise my right to the ARRA 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) COBRA 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

I make an election to exercise my right to the ARRA 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)

c. _____

1. I elected (or am electing) COBRA 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

I make an election to exercise my right to the ARRA 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 ➤ _____