Request for Treatment as an Assistance Eligible Individual

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

To apply for a Consolidated Omnibus Budget Reconciliation Act (COBRA) premium subsidy under the American Rescue Plan Act (ARPA) of 2021, submit this form **within 60 days** of the date on the enclosed letter. If you do not submit the form by the required due date, you may lose your right to receive the premium subsidy.

If you are already enrolled in PEBB Continuation Coverage or PEBB retiree insurance coverage, send only this form to the address at the end of this form.

If you are not enrolled in PEBB Continuation Coverage or PEBB retiree coverage, submit both the *COBRA Subsidy Election Form for PEBB Continuation Coverage* and this form to the address at the end of this form.

If you do not qualify for the premium subsidy but are newly eligible for continuation coverage and want to enroll, do not use this form. Submit the *2021 PEBB Continuation Coverage (COBRA or Unpaid Leave) Election/Change* form. The form is on the HCA website at **hca.wa.gov/pebb-continuation** under *Forms & publications*, or call 1-800-200-1004 (TRS: 711) to request a form.

You may also want to read important information about your rights in the enclosed *Summary of the COBRA Premium Subsidy Provisions Under ARPA*.

1 Subscriber

Social Security number

Last name

First name

Middle initial

Address

Address line 2

City

State

ZIP code

Date of birth

Phone number

To qualify for the medical subsidy, you must be able to check "Yes" for all five statements below.

1. I lost eligibility for employer-paid health benefits due to a reduction of hours or involuntary termination. ☐ Yes ☐ No
2. The loss of employment or reduction of hours occurred between October 1, 2019 and August 31, 2021. ☐ Yes ☐ No
3. I elected (or am electing) PEBB Continuation Coverage or PEBB retiree insurance coverage. ☐ Yes ☐ No
4. I am not eligible for other group medical coverage, or I was not eligible for other group medical coverage during the period for which I am claiming a subsidy. (Checking Yes means you are/were NOT eligible for other coverage.) ☐ Yes ☐ No
5. I am not eligible for Medicare, or I was not eligible for Medicare during the period for which I am claiming a subsidy. (Checking Yes means you are/were NOT eligible for Medicare) ☐ Yes ☐ No

To qualify for the dental subsidy, you must be able to check "Yes" for this statement.

6. I am not eligible for other group dental plan coverage, or I was not eligible for other group dental plan coverage during the period for which I am claiming a subsidy. (Checking Yes means you are/were NOT eligible for other dental coverage.) ☐ Yes ☐ No

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

Social Security number

Last name

First name

Middle initial

Address

Address line 2

City

State

ZIP code

Date of birth

Phone number

To qualify for the medical subsidy, you must be able to check "Yes" for all five statements below.

1. The subscriber lost eligibility for employer-paid health benefits due to a reduction of hours or involuntary termination. ☐ Yes ☐ No
2. The subscriber's loss of employment or reduction of hours occurred between October 1, 2019 and August 31, 2021. ☐ Yes ☐ No
3. I (the spouse or SRDP) elected (or am electing) PEBB Continuation Coverage. ☐ Yes ☐ No
4. I (the spouse or SRDP) am not eligible for other group medical coverage, or I was not eligible for other group medical coverage during the period for which I am claiming a subsidy. (Checking yes means you are/were NOT eligible for other group coverage.) ☐ Yes ☐ No
5. I (the spouse or SRDP) am not eligible for Medicare, or I was not eligible for Medicare during the period for which I am claiming a subsidy. (Checking yes means you are/were NOT eligible for other Medicare.) ☐ Yes ☐ No

To qualify for the dental subsidy, you must be able to check "Yes" for this statement.

6. I (the spouse or SRDP) am not eligible for other group dental plan coverage, or I was not eligible for other group dental plan coverage during the period for which I am claiming a subsidy. (Checking yes means you are/were NOT eligible for other dental coverage.) ☐ Yes ☐ No

Subscriber's last name

Social Security number

3 Dependent

Use additional forms for more dependents. List only dependents eligible under PEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and children age 26 or older with a disability.

Social Security number

Last name

First name

Middle initial

Address

Address line 2

City

State

ZIP code

Date of birth

Phone number

To qualify for the medical subsidy, you must be able to check "Yes" for all five statements below.

1. The subscriber lost eligibility for employer-paid health benefits due to a reduction of hours or involuntary termination. ☐ Yes ☐ No
2. The subscriber's loss of employment or reduction of hours occurred between October 1, 2019 and August 31, 2021. ☐ Yes ☐ No
3. I (the dependent) elected (or am electing) PEBB Continuation Coverage. ☐ Yes ☐ No
4. I (the dependent) am not eligible for other group medical coverage, or I was not eligible for other group medical coverage during the period for which I am claiming a subsidy. (Checking yes means you are/were NOT eligible for other group coverage.) ☐ Yes ☐ No
5. I (the dependent) am not eligible for Medicare, or I was not eligible for Medicare during the period for which I am claiming a subsidy. (Checking yes means you are/were NOT eligible for other Medicare.) ☐ Yes ☐ No

To qualify for the dental subsidy, you must be able to check "Yes" for this statement.

6. I (the dependent) am not eligible for other group dental plan coverage, or I was not eligible for other group dental plan coverage during the period for which I am claiming a subsidy. (Checking yes means you are/were NOT eligible for other dental coverage.) ☐ Yes ☐ No

Subscriber's last name

Social Security number

4 Signatures

I make an election to exercise my right to ARPA premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Subscriber's signature

Date

Spouse's or state-registered domestic partner's signature (*if applying*)

Date

Dependent's signature *(Parent or guardian should sign for minor children)*

Date

Please sign and date this form, and submit it to the PEBB Program **within 60 days** of the date on the enclosed letter. If you are applying for PEBB Continuation Coverage, also send the *COBRA Subsidy Election Form for PEBB Continuation Coverage*.

Mail to:

Washington State Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

Electronically submit:

Send a secure online message to PEBB Customer Service by registering for an account on HCA's website at **hca.wa.gov/fuze-questions**. Sign and date any forms you attach to a secure message.

Fax to:

1-360-725-0771

For further assistance, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272, or at **askebsa.dol.gov/WebIntake**.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call the PEBB Program at 1-800-200-1004 (TRS: 711).

HCA's Privacy Notice: HCA will keep your information private as allowed by law. To see our Privacy Notice, go to HCA's website **hca.wa.gov/pebb-continuation**.