Attestation of Eligibility

PacificSource HEALTH PLANS

Requirements of an Assistance Eligible Individual (AEI) to receive COBRA/State continuation support through the American Rescue Plan Act (ARPA)

To qualify for premium assistance for periods of coverage from April 1, 2021, through September 30, 2021, you and any qualified dependents must meet these four requirements:

1. The COBRA/State continuation qualifying event was a loss of employment that was involuntary or a reduction of hours.
2. You elected (or are electing) COBRA/State 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).

☐ I have reviewed this information and the notice of my rights under the ARPA. I hereby attest that I meet the requirements for treatment as an Assistance Eligible Individual (AEI). I further affirm that I am not now eligible for coverage under another group health plan or Medicare; I understand that if I become eligible for coverage under another group health plan or Medicare, 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/State 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/State continuation 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 _____

Type or print name _____

Mailing address _____

Qualified Dependents

Name _____

Name _____

Name _____

Name _____

Name _____

If you believe that you are eligible for the AEI subsidy, please complete this form and send it with your benefits election form to:

Employer name _____

Address _____

_____

If you have questions about COBRA/State continuation, the ARP, premium reduction, or this Attestation of Eligibility Form, please contact our Customer Service Department at **888-977-9299, TTY711,** during business hours. Or email CS@PacificSource.com.