

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

**Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.**

UAW/UMass Health & Welfare  
Trust Fund

**Participant Notification**

329 Middlesex House,  
111 County Circle  
Amherst, MA 01003-  
9255

**PERSONAL INFORMATION**

Name and mailing address

Telephone number

E-mail address (optional)

**PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one**

I am eligible for coverage under another group health plan.  
If any dependents are also eligible, include their names below.

Insert date you became eligible \_\_\_\_\_

I am eligible for Medicare.

Insert date you became eligible \_\_\_\_\_

**IMPORTANT**

**If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.**

**Eligibility is determined regardless of whether you take or decline the other coverage.**

**However, eligibility for coverage does not include any time spent in a waiting period.**

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 → \_\_\_\_\_

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

\_\_\_\_\_

\_\_\_\_\_

