To verify your eligibility to receive Premium Assistance under the American Rescue Plan Act of 2021 (ARPA), complete this form and return it to WageWorks. If you have not yet elected COBRA continuation coverage, you may send this form along with your COBRA election form. If you do not complete this form and return it within 60 days of the date of your notice, you may be unable to receive the premium assistance.

If you are already enrolled in COBRA, you may complete this form separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: WageWorks, Inc. at PO Box 226101 Dallas, TX 75222-6101. You may also fax the completed form to 866.599.3141. You may also submit this information electronically at compliancedepartment@healthequity.com (PLEASE USE "Request for Treatment as an AEI" IN YOUR EMAIL'S SUBJECT LINE).

For more information regarding ARPA premium assistance and eligibility questions, visit https://www.dol.gov/cobra-subsidy.

HealthEquity WageWorks

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

P.O. Box 650407
Dallas, TX 75265-0407

PERSONAL INFORMATION

Name, mailing address, and employee's Account Number (if you do not know the employee's account number, please list the employee's Social Security number; list any dependents in the "Dependent Information" section of this form)	Primary Telephone number E-mail address (required)

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

1. The qualifying event was an involuntary termination of employment or a reduction in hours.	☐ Yes ☐ No
2. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
3. 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 premium assistance).	☐ Yes ☐ No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	☐ Yes ☐ No

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.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

FOR EMPLOYER OR PLAN USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason in #3 below and 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.	☐
2. Individual did not experience a reduction in hours.	☐
3. Individual did not elect COBRA coverage.	☐
4. Other (please explain)	☐

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

_____ Date _____

Type or print name _____

Telephone number _____ E-mail address _____

For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272, or online at https://www.askebsa.dol.gov/WebIntake.

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name

Date of Birth

Relationship to Employee

SSN (or other identifier)

. _____

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No

I make an election to exercise my right to ARPA premium assistance. 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)

. _____

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No

I make an election to exercise my right to ARPA premium assistance. 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)

. _____

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes ☐ No
3. I am NOT eligible for Medicare.	☐ Yes ☐ No
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No

I make an election to exercise my right to the ARPA premium assistance. 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 _____