

If you begin receiving COBRA premium assistance pursuant to the ARP, use this form to notify the Fund Office that you have become eligible for other group health plan coverage or Medicare and therefore are no longer eligible for premium assistance under the ARP.

IATSE National Health and Welfare Fund

Participant Notification

417 Fifth Avenue, 3rd Floor, New York, NY 10016
COBRA@iatsenbf.org

PERSONAL INFORMATION

Name and mailing address

Telephone number

E-mail address (optional)

PREMIUM ASSISTANCE 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 the Fund when you become eligible for other group health plan coverage or Medicare AND continue to receive COBRA premium assistance you may be subject to a penalty of \$250 (or if the failure is fraudulent, the greater of \$250 or 110% of the amount of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the Fund is due to reasonable cause and not due to willful neglect.

Eligibility for other coverage 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:
