

PARTICIPANT NOTIFICATION

Use this form to notify the Benefit Services Division that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under ARRA.

PERSONAL INFORMATION

Participant full name and mailing address	Telephone Number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION

(INDIVIDUAL(S) LISTED BELOW IS/ARE NOW ELIGIBLE FOR OTHER GROUP HEALTH PLAN COVERAGE OR MEDICARE)

LAST NAME, FIRST NAME, M.I.	MEDICARE	OTHER GROUP HEALTH PLAN	DATE OF ELIGIBILITY	APPLICABLE COBRA ENROLLMENT DECISION
LIST FULL NAME (INCLUDE DEPENDENTS)	CHECK BOX	CHECK BOX	LIST DATE	CIRCLE ONE ELECTION
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
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	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES
	<input type="checkbox"/>	<input type="checkbox"/>	/ /	DISCONTINUE ENROLLMENT / CONTINUE AT FULL COBRA RATES

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 premium assistance received after eligibility is lost.

Signature _____ Date _____

Type or print name _____

Please return this form to: **ADOA Benefit Services Division**
100 North 15th Avenue, Suite 103
Phoenix, Arizona 85007

Or fax this return form to: **(602) 542-4744**
Attention: Samantha Roberts