Health Net Health Plan of Oregon, Inc.
State Continuation Election / Premium Subsidy Attestation
American Recovery and Reinvestment Act

To elect Oregon state continuation coverage, complete this election form and return it TO THE EMPLOYER. You have 31 days from the date your coverage terminates to decide whether or not you want to elect state continuation. If you do not submit a completed election form within the required time period, you will lose your right to continuation coverage.

Employer Name		**Group No.**	
Employee Name		**Soc Sec No.**	

Required

***** If you have previously elected continuation coverage and are applying for the ARRA subsidy, go to the Attestation on the next page *****

Loss of coverage reason ☐ Layoff or reduction in force ☐ Reduction in hours ☐ Voluntary termination or termination for cause ☐ No longer eligible ☐ Other (please explain):____________________	**Date of Event**	

I understand that I am eligible to self-pay my present Health Net of Oregon group medical coverage for up to nine months if I have been covered under the group contract for three months.

☐ Yes, I want to continue my group medical insurance through Oregon State Continuation.

1. I am not eligible for Medicare. I will notify the Subscriber Group if I become eligible for Medicare.
2. I am not eligible for any other group medical insurance coverage. I will notify the Subscriber Group if I become eligible for any other group medical insurance coverage.
3. I understand I must pay any owed premium to my Subscriber Group administrator (my Employer) each month in advance of the coverage effective date. Premium for the first month is included with this form.
4. I understand that portability coverage is available as described in my group benefit materials.
5. I wish to remain insured by my present group coverage:
   ☐ SELF Only ☐ SELF and CURRENTLY COVERED FAMILY MEMBERS
   ☐ Medical Only ☐ Dental Only ☐ Medical and Dental

Oregon Registered Domestic Partners (and other Domestic Partners if added by endorsement to the contract) **are** eligible for state continuation coverage under an Oregon group employer plan.

Please list all dependents to be covered with the employee

Required

Dependent Name		**Soc Sec No.**	
☐ Domestic Partner			
Dependent Name		**Soc Sec No.**	
Dependent Name		**Soc Sec No.**	
Dependent Name		**Soc Sec No.**	
Dependent Name		**Soc Sec No.**	

☐ Another page is attached with required information for additional dependents.

Signature		Date	

☐ **No, I am not interested in continuing my group medical insurance through Oregon State Continuation.**

Signature		Date	

Federal premium reduction is not available for domestic partner coverage. The full cost of coverage for a domestic partner on state continuation coverage will be included in the amount you must pay.

Attestation of Eligibility for the American Recovery and Reinvestment Act Premium Reduction

1. The loss of employment was involuntary	☐ Yes ☐ No
2. The loss of employment occurred on or after September 1, 2008 and on or before December 31, 2009	☐ Yes ☐ No
3. I elected state continuation coverage *If "No," you may still be eligible – see "Additional Election Period" at the bottom of this form*	☐ Yes ☐ No
4. 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 a reduced premium eligibility)	☐ Yes ☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium eligibility)	☐ Yes ☐ No
6. I am currently receiving employer contributions to pay my health care premiums If Yes, how much are you receiving? If Yes, when will contributions from your employer end?	☐ Yes ☐ No

I am making an election to exercise my right to the American Recovery and Reinvestment Act Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature ______________________________ Date ____________________

Additional Election Period

If your state continuation coverage relates to an involuntary loss of employment from September 1, 2008 through April 27, 2009 and:

- you were eligible for, but did not elect state continuation coverage, OR
- you elected but then discontinued state coverage

you may have the right to have an additional 31-day election period.

Employer Attestation for Premium Reimbursement

This application is:

☐ Approved ☐ Denied ☐ Approved for some applicants

Please explain: ______________________________

The reason for the denial is:

☐ The loss of employment was voluntary
☐ The involuntary loss did not occur between September 1, 2008 and December 31, 2009.
☐ The individual did not elect continuation coverage
☐ Other

Please explain: ______________________________

Signature of person responsible for continuation coverage administration under the plan ______________________________ Date ____________

EMPLOYER – AFTER SIGNATURE RETURN THIS FORM TO HEALTH NET AT ADDRESS BELOW - KEEP A COPY FOR YOUR FILES

Attn: Ruth Giron
21281 Burbank Blvd.
LNR-C4
Woodland Hills, CA 91367

Dependent Continuation Election / Attestation

Use this section of the form when only dependents are enrolling for state continuation.

****If you have elected continuation coverage and are applying for the ARRA subsidy, go to the Attestation on the next page****

Oregon Registered Domestic Partners (and other Domestic Partners if added by endorsement to the contract) **are** eligible for state continuation coverage under an Oregon group employer plan.

Loss of coverage reason ☐ Spouse/child(ren) losing coverage because of employee's loss of employment ☐ Spouse and child(ren) upon dissolution of marriage or death of employee ☐ Legally separated or divorced spouse age 55 or older/child(ren) ☐ Surviving spouse age 55 or older/child(ren) ☐ Other (please explain):______________________	**Date of Event**	

☐ **Yes, I want to continue my group medical insurance through Oregon State Continuation.**

1. I am not eligible for Medicare. I will notify the Subscriber Group if I become eligible for Medicare.
2. I am not eligible for any other group medical insurance coverage. I will notify the Subscriber Group if I or become eligible for any other group medical insurance coverage.
3. I understand I must pay any owed premium to my Subscriber Group administrator (the Employer) each month in advance of the coverage effective date. Owed premium is included with this form.
4. I understand that portability coverage is available if I have been covered under a health benefit plan for 180 days and that I must apply within 60 days after my group medical benefits terminate.
5. I wish to remain insured by my present group contract for up to nine months.
   ☐ SELF Only ☐ SELF and CURRENTLY COVERED FAMILY MEMBERS
   ☐ Medical Only ☐ Dental Only ☐ Medical and Dental

Please list all dependents to be covered

Required

Dependent Name		**Soc Sec No.**	
☐ Domestic Partner			
Dependent Name		**Soc Sec No.**	
Dependent Name		**Soc Sec No.**	
Dependent Name		**Soc Sec No.**	
Dependent Name		**Soc Sec No.**	

☐ Another page is attached with required information for additional dependents.

Signature		**Date**	
Relationship to the Employee			

Federal stimulus reimbursement is not available for domestic partner coverage. The cost of coverage for a domestic partner on state continuation coverage will be included in the amount you must pay with respect to federal stimulus reimbursement.

Attestation of Eligibility for the American Recovery and Reinvestment Act Premium Reduction

1. **I elected (or am electing) state continuation coverage** *If "No," you may still be eligible – see "Additional Election Period" below*	☐ Yes ☐ No
2. **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 a reduced premium eligibility)	☐ Yes ☐ No
3. **I am NOT eligible for Medicare** (or I was not eligible for Medicare during the period for which I am claiming a reduced premium eligibility)	☐ Yes ☐ No
4. **I am currently receiving employer contributions to pay my health care premiums** **If Yes, how much are you receiving?** **If Yes, when will contributions from your employer end?**	☐ Yes ☐ No

I am making an election to exercise my right to the American Recovery and Reinvestment Act Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature ______________________________ Date ____________________

Additional Election Period

If your state continuation coverage relates to the employee's involuntary loss of employment from September 1, 2008 through April 27, 2009 and:

- you were eligible for, but did not elect state continuation coverage, OR
- you elected but then discontinued state coverage

you may have the right to have an additional 31-day election period.

Employer Attestation for Premium Reimbursement

This application is:

☐ Approved ☐ Denied ☐ Approved for some applicants

Please explain: ____

The reason for the denial is:

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☐ The involuntary loss did not occur between September 1, 2008 and December 31, 2009.
☐ The individual did not elect continuation coverage
☐ Other

Please explain: ____

Signature of person responsible for continuation coverage administration under the plan		**Date**	

EMPLOYER – AFTER SIGNATURE RETURN THIS FORM TO HEALTH NET AT ADDRESS BELOW - KEEP A COPY FOR YOUR FILES

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