American Recovery and Reinvestment Act of 2009

Temporary Continuation of Coverage (TCC) Premium Assistance

Part A – Assistance Eligible Individual Information
Enrollee Name (last, first, middle initial)
Home mailing address (including ZIP Code) -
Social Security Number
Telephone Number

This is to request premium assistance under the American Recovery and Reinvestment Act of 2009.
I am not eligible for Medicare or any group health coverage other than through the Federal Employees Health Benefits (FEHB) Program. I was involuntarily separated from Federal employment on [*Date*] _____, and the separation was not for gross misconduct. I understand that if I become eligible for other group health coverage or Medicare, I will be disqualified from continuing to receive premium assistance. I agree to notify my FEHB Program health plan and my former employing agency immediately if I become eligible for other group health coverage. If I do not make the required notification, I understand I am subject to a penalty of 110 percent of any premium assistance provided after termination of eligibility for premium assistance.

_____ _____

Signature *Date*