

EMPLOYER ATTESTATION FOR STATE CONTINUATION OF COVERAGE SUBSIDY

A separate attestation is required for each employee subsidy requested. This form must be completed each month the subsidy is taken (15 months maximum). The subsidy cannot be requested for any month until the employer has received the employee's payment of his/her portion (35%) of the premium for that month.

Mail this form to: Tufts Health Plan
Attn: Enrollment & Premium Billing
P.O. Box 9186
Watertown, MA 02471-9186

Employer Group Name: _____

Employer Group Number: _____

I certify that the employer group named above is not subject to federal COBRA, but instead the employer is subject to state continuation of coverage. The employee listed below was involuntarily terminated on or after 9/1/2008 and on or before 5/31/2010. The employee and/or dependents listed below are eligible for subsidy. I understand that domestic partners/same-sex spouses and their dependents are not eligible for subsidy. The employee has paid his/her 35% share of the continuation premium for the subsidy month being requested.

Signature _____ **Title** _____ **Date** _____

Employee/dependent(s) eligible for 65% subsidy

Employee name: _____

Employee SSN (required) _____

If dependents are covered under the plan, list names and relationship of all dependents. (e.g. spouse, ex-spouse, domestic partner/same-sex spouse, child, domestic partner's child, etc.)

Name	Relationship	SSN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Involuntary Termination date _____

COC original effective date _____

Subsidy month requested _____ (3/1/09 earliest date)

COC premium charged to employee _____

COC premium billed by Tufts Health Plan _____

Payment amount received from the participant above is \$_____. (This is 35% of the Tufts Health Plan billed amount, and 35% of the 2% administration fee, if charged.)

Amount submitted to Tufts Health Plan for the participant above is: \$_____ (If you charged the employee the 2% administration fee, please retain the 2% from the employee's payment).

Subsidy Amount Requested _____ (If a domestic partner/same-sex spouse and/or that person's dependents are covered on this plan, they are not eligible for subsidy. See below for examples of how to calculate the subsidy. If the rate billed to the employee includes the 2% administration fee, Tufts Health Plan will reimburse the employer 65% of the 2% we subsidize. See example 1 below.)

Example 1: Employee pays 102% of Tufts Health Plan billed rate.

Tufts Health Plan billed \$1000.00 for FAM Coverage
Employee charged \$1020.00 for coverage by the Employer (includes 2% administration fee)
With subsidy employee pays \$357.00 to Employer
Employer remits \$350.00 to Tufts Health Plan
Employer requests subsidy of \$663.00 from Tufts Health Plan (which includes 2% for administration fee)
Tufts Health Plan will reimburse/credit the employer \$13 for the administration fee

Example 2 tier rate with domestic partner/same-sex spouse.

IND rate is \$400.00
FAM rate is \$1000.00

\$740.00. The subsidy amount requested from Tufts Health Plan would be \$260.00.

If subscriber and domestic partner/same-sex spouse are enrolled on COC and are paying the family rate, only the subscriber is eligible for the subsidy.

If the subscriber, a domestic partner/same-sex spouse, and the subscriber's dependent children are enrolled on COC, the full family rate is eligible for subsidy. The subscriber would pay 35% of the \$1000.00, equal to \$350.00, and the subsidy amount requested from Tufts Health Plan would be \$650.00.

The subscriber would need to pay 35% of the \$400.00, equal to \$140.00, plus the balance of the rate \$600.00 for the domestic partner/same-sex spouse, for a total of

Example 3 or 4 tier rates.

IND rate is \$400.00
2SSP (employee and spouse) rate is \$750.00
2SCH (employee and child) rate is \$750.00
FAM rate is \$1000.00

portion of the rate is eligible for subsidy. The subscriber would pay 35% of \$750 (charge for the two person plan), for a total of \$262.50, plus the \$250.00 balance for the family rate for the domestic partner/same-sex spouse—a total of \$512.50. The subsidy amount requested from Tufts Health Plan would be \$487.50 (65% of \$750).

If subscriber, a domestic partner/same-sex spouse, and subscriber's dependent child are enrolled on COC, only a