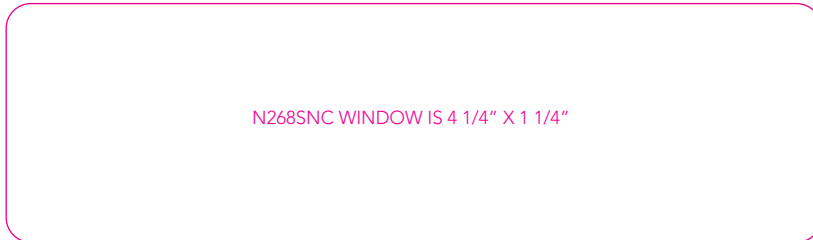


Application for Treatment as an Assistance Eligible Individual

To apply for the ARRA Premium Reduction, complete this form and return it to your former Health Benefits Representative.

PERSONAL INFORMATION



Telephone Number

ID Number

| | |
|---|--|
| 1. The loss of employment was involuntary. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I elected (or am electing) COBRA continuation coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. I elected (or am electing) to continue my coverage through RIF benefits and electing COBRA continuation coverage for my dependents. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. 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). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium). | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Employee Signature: _____ Date: _____

Type or print name: _____

List dependents to be covered below and on the back.

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

| A | Name | Date of Birth | Relationship to Employee | SSN (or other identifier) |
|---|------|---------------|--------------------------|---------------------------|
| | | | | |

| | |
|--|--|
| 1. I elected (or am electing) COBRA continuation coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I am NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I am NOT eligible for Medicare. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I make an election to exercise my right to the ARRA 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: _____

Type or print name: _____ Relationship to employee: _____

| B | Name | Date of Birth | Relationship to Employee | SSN (or other identifier) |
|---|------|---------------|--------------------------|---------------------------|
|---|------|---------------|--------------------------|---------------------------|

| | |
|--|--|
| 1. I elected (or am electing) COBRA continuation coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I am NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I am NOT eligible for Medicare. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I make an election to exercise my right to the ARRA 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: _____

Type or print name: _____ Relationship to employee: _____

| C | Name | Date of Birth | Relationship to Employee | SSN (or other identifier) |
|---|------|---------------|--------------------------|---------------------------|
|---|------|---------------|--------------------------|---------------------------|

| | |
|--|--|
| 1. I elected (or am electing) COBRA continuation coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. I am NOT eligible for other group health plan coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I am NOT eligible for Medicare. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I make an election to exercise my right to the ARRA 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: _____

Type or print name: _____ Relationship to employee: _____

FOR EMPLOYER USE ONLY

This application is: Approved Denied, specify reason below.

Return a copy of this form to the applicant, keep a copy to meet your reporting requirements and send a copy to NC State Health Plan, Attention: Membership Services, PO Box 30111, Durham, NC 27702.

REASON FOR DENIAL AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

| | |
|--|--|
| 1. Loss of employment was voluntary. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Other (please explain): | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Signature of employer: _____ Date: _____

Type or print name: _____

Telephone Number: _____ E-mail address: _____