Application for COBRA Premium Assistance for Entertainment Industry Employees

The New York State COBRA Premium Assistance Program helps entertainment industry employees maintain health coverage. Eligible applicants can receive premium assistance equal to 75% of their COBRA premiums for up to 12 months.

NOTE ON CONFIDENTIALITY: The information you provide on this application will be kept confidential and will only be provided to the state agencies that oversee the program, process payments, or conduct audits.

To qualify for this program:

- You must be a resident of New York state.
- You must be currently receiving, or eligible to receive, COBRA continuation coverage through an entertainment industry union fund.
- You must not already be receiving continuation assistance from a Department of Health program.
- You must not be eligible for Medicare.
- You must not be eligible for employer sponsored coverage.
- Your gross monthly household income must meet the limits listed in the chart below. Gross income means income before taxes are taken out or other deductions are made. All types of income earned during the month should be included, not just entertainment industry related income.

Number of People in Household	Gross Monthly Household Income
1	Up to $ 4,530
2	Up to $ 6,103
3	Up to $ 7,677
4	Up to $ 9,250
5	Up to $ 10,823
Each extra person	Add $ 1,573

Send this application and your supporting documentation by email to : COBRA.application@dfs.ny.gov

Or by mail addressed to:

NYS Continuation Assistance Program
NYS Department of Financial Services
One Commerce Plaza, Suite 1909
Albany, NY 12257

Section 1. Your Contact Information

1. Legal Name (First, MI, Last): _____
2. Stage Name (if applicable): _____
3. Phone Number: _____
4. Email Address: _____
5. Home Address (Residence): _____

   _____
6. County of Residence: _____
7. Mailing Address (if different than home address):

   _____

   _____
8. County of Mailing Address: _____
9. Are you a New York State resident? ☐ Yes ☐ No

Section 2. Entertainment Industry Union Fund Information

Enter your entertainment industry union fund information. You must be currently eligible for, or currently receiving COBRA continuation coverage from an entertainment industry union. If this does not apply to you, you are not eligible for this program. Provide the following information about your union fund membership:

1. Union Fund Name: _____

   Union Fund Address: _____

   _____

   _____
2. Have you applied to this COBRA assistance program before? ☐ Yes ☐ No
3. Please provide a brief description of your most recent entertainment job:

   _____

   _____

   _____

   _____

Section 3. COBRA Continuation Coverage Information

Answer questions about your COBRA continuation coverage, including the first month for which you are seeking premium assistance. No retroactive premium assistance will be provided. Attach documents showing your COBRA continuation coverage eligibility, including start and/or end date.

1. What date did you, or will you, become eligible for COBRA continuation coverage?

   _____

2. What date will your COBRA continuation coverage end?

   _____

3. What is the first month that you are seeking COBRA premium assistance? (Premium assistance cannot be provided for past months.) _____

4. What is the full amount of your COBRA premium? $_____

5. How often do you pay your COBRA premium? ☐ Month ☐ Quarter ☐ Other (please explain)

   _____

6. **Attach a copy of the notification letter provided by your union fund stating that you are eligible for COBRA continuation coverage**. This letter must include the start and/or end date for your COBRA continuation coverage eligibility. Do not send a certificate showing when your coverage ended.
   Is a copy of the notification letter attached? ☐ Yes ☐ No

7. How many people (including yourself) will be covered by the COBRA continuation policy?

   _____

Section 4. Gross Monthly Household Income (Previous Calendar Month)

- **List the monthly gross income for both you and your spouse (if they live in your house) for the previous full calendar month only. (For example, if you are applying in February, provide your gross income for January.) Provide your exact income, not an estimate.**
- **Include all of income received in the previous full calendar month, no matter when the income was earned. For example, if a paycheck is dated 11/1 but the pay period is 10/24-10/31, this paycheck would count toward your November income.**
- **Include all wages, salary, interest and dividends, self-employment income, unemployment benefits, social security income, retirement income, alimony, workers compensation, rental income, royalties, and residual fees.**
- **Do not include gifts, public assistance, supplemental security income (SSI), foster care payments or child support received.**

1. Your Monthly Gross Income $_____
2. Your Spouse's Monthly Gross Income $_____
3. Total Monthly Gross Income $_____

4. If you indicated that you have $0 income above or your documentation only represents part of the month, please explain:

_____

_____

_____

5. Please attach documentation of your household income for the previous full calendar month. Applications without complete documentation will not be processed. The following are examples of acceptable documentation. Please place a checkmark next to the type of documents that you have attached.

- ☐ Copies of pay stubs, paychecks, or gross earnings statements
- ☐ Printout of unemployment payments
- ☐ Self-employment documents (i.e., bank statements, business records, invoices, etc.)
- ☐ Bank account statements
- ☐ Statements from Venmo, PayPal, or similar online payment applications or platforms.
- ☐ Other (please explain)

6. This program's household income limits depend on the size of your family. For the purposes of this program "family" means you, your spouse (if they live in your house) and any dependents who are eligible to be covered under your policy. The number of people in your family does not need to be the same as the number of people that are covered under your COBRA insurance. In other words, count your spouse, even if you are only seeking coverage for yourself.

How many people are in your family? _____

Section 5. Certification (Please Read This Section Carefully)

By signing below, I certify that all statements and answers contained in this application are true.

I also certify that I am not eligible for Medicare and that I am not receiving other COBRA premium assistance.

I acknowledge that I will lose my eligibility for premium assistance on the date that any of the following occur:

- My COBRA continuation coverage ends;
- I move outside of New York state;
- I become eligible for Medicare; or
- I become eligible for employer coverage or union-sponsored health coverage.

I will immediately notify the New York State COBRA Premium Assistance Program of any changes to the above information:

by sending an email to: COBRA.application@dfs.ny.gov

or by sending a letter addressed to:

NYS Continuation Assistance Program
NYS Department of Financial Services
One Commerce Plaza, Suite 1909
Albany, NY 12257

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Full Name: _____

Signature_____ Date_____

Electronic signature may be used instead of a handwritten signature. The use of an electronic signature has the same validity and effect as the use of a handwritten signature.