



NYS Continuation Assistance Program Application for Entertainment Industry Employees



This program assists eligible entertainment industry employees in maintaining health insurance. Eligible applicants shall receive assistance equal to 50% of their COBRA premiums for a lifetime total of up to 12 months.

Application Instructions

SECTION 1 Applicant Information

In this section we ask how for your contact information. **The program is only available to New York State residents.**

SECTION 2 Entertainment Industry Information

To qualify for this program you must be currently receiving or eligible for COBRA continuation coverage through an entertainment industry union fund. Please provide your entertainment industry union fund information in Section 3.

SECTION 3 COBRA Continuation Coverage

Please answer the questions in Section 3 about your COBRA continuation coverage, including the first month that you are seeking assistance for. **We cannot provide retroactive premium assistance. You may apply for assistance in the current month if your application is received by the 15th of the month, otherwise premium assistance will begin next month.**

Please attach documentation of your COBRA continuation coverage eligibility.

SECTION 4 Household Income

| Family Size | Monthly Household Income |
|--------------|--------------------------|
| 1 | Up to \$2,394 |
| 2 | Up to \$3,232 |
| 3 | Up to \$4,070 |
| 4 | Up to \$4,908 |
| 5 | Up to \$5,746 |
| Extra person | Add \$838 |

Amounts updated annually.

Pregnant women count as 2 people.

In order to qualify for the NYS Continuation Assistance Program, your household income must fall within the limits established for the program. Please list your current **gross** monthly income and the current **gross** monthly income of your spouse (if residing in your household) in the space provided in Section 4. Do not count income for any other household member.

You may count your domestic partner as a spouse for this program if he/she is covered as a dependent under your policy.

Important -- Please use your income from the **previous full calendar month only**. All income must be counted, not just entertainment related income.

Please include wages, salary, self-employment income, interest and dividends, social security income, retirement income, alimony, unemployment benefits, workers compensation, royalties and residual payments. Please **do not** include gifts, public assistance, supplemental security income (SSI), foster care payments or child support payments you receive.

The NYS Continuation Assistance Program income limitations vary by household size. Refer to the chart to determine if you meet the household income requirements.

Please attach documentation of your gross household income for the previous full calendar month.

SECTION 5 Certification

Please carefully review and complete the certification in Section 5.

SUBMITTING YOUR APPLICATION

Important – Please review your application and ensure that each section has been fully completed.

Submit your application to the following address:
NYS Continuation Assistance Program
NYS Department of Financial Services
P.O. Box 7184
Albany, NY 12224-0184

QUESTIONS? Please call (518) 486-7815 or e-mail us at cobraprogram@dfs.ny.gov. For more information, please visit: www.dfs.ny.gov/insurance/cobra/cobra_entertainment.htm

Confidentiality Statement: All of the information you provide on this application will remain confidential. The information will only be provided to the state agencies that oversee the program and process payments.



NYS Continuation Assistance Program



Application for Entertainment Industry Employees

SECTION 1 Applicant Information

| | | | |
|---|-------|------------------|--------|
| <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | | | |
| Legal Name: First _____ MI _____ Last _____ | | | |
| Stage Name (if applicable): | | | |
| Telephone No.: | | Evening () | |
| Day () | | | |
| Home Address (Residence): Please note - you <u>must</u> be a New York State resident. | | | |
| Street | | | |
| City | State | Zip | County |
| Mailing Address (if different than home address): | | | |
| Street | | | |
| City | State | Zip | County |

SECTION 2 Entertainment Industry Information

1. Are you currently eligible for, or receiving, COBRA continuation insurance from an entertainment industry union? (Note: if this does not apply to you, you are not eligible for this program.)

- Yes, I am currently eligible for, or receiving, COBRA continuation insurance from an entertainment industry union fund.

Please provide the following information about your union fund membership:

Fund Name: _____

Fund Address: _____

2. Have you applied for 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

1. Please provide the date you became or will become eligible for COBRA continuation coverage:

2. Please provide the date when your eligibility for COBRA continuation coverage ends:

3. Please indicate the first month for which you are seeking COBRA assistance: _____

IMPORTANT! Premium assistance cannot be provided for prior months. You may apply for assistance in the current month if your application is received on or before the 15th of the current month. Otherwise, premium assistance will begin in the following month.

4. Please provide the full amount of your COBRA continuation insurance premium: \$ _____

This premium is due every: Month Quarter Other (please explain) _____

5. Please attach a copy of the notification letter provided by your union fund stating your COBRA continuation coverage eligibility. This letter must include the dates for which you are eligible for COBRA continuation coverage. **Do not send a certificate of creditable coverage.**

Notification letter attached? Yes No

6. Please provide the number of people (including yourself) who will be covered by the COBRA continuation policy: _____.

SECTION 4 Household Income

1. Please list the **monthly gross income** for both you and your spouse for the **previous full calendar month only**. (For example, if you are applying in February, please provide gross income for January.) You may count your domestic partner as a spouse for this program if he/she is covered under your policy. Please include all income received in the **previous full calendar month**, regardless of when the income was earned. (For example: if a paycheck is dated 11/1 but the pay period is 10/24-10/31, this would count toward November income.) **You must include exact income, not an estimate.**

Please include wages, salary, interest and dividends, self-employment income, social security income, retirement income, alimony, unemployment benefits, workers compensation, royalties and residual fees. Please **do not** include gifts, public assistance, supplemental security income (SSI), foster care payments or child support received.

All income is to be counted, including any non-entertainment related income.

Applicant's Monthly Gross Income \$ _____
Spouse's Monthly Gross Income \$ _____
Total** \$ _____

**** If you have indicated \$0 income in question 1 above OR your documentation only represents a partial month (e.g. 2 weeks), please explain below.**

2. **IMPORTANT!** You must attach documentation of your household income for the previous full calendar month. The following are examples of acceptable documentation:

- Pay Stubs
- Copies of paychecks
- Letter from employer
- Printout of unemployment payments
- Self-employment documents (i.e. bank statements, business records, invoices, etc.)
- Other (please explain) _____

3. The household income limits vary, depending upon your family size (see instructions). Please provide the number of people in your family (pregnant woman count as two people when determining family size): _____.

For the purposes of this program "family" means yourself, your spouse (if residing in your household) and any dependents eligible for coverage under your policy. Count your domestic partner if he/she is covered under your insurance. Please note that the number of people in your family does not need to be the same as the number of people being covered under your COBRA insurance. (In other words, count your spouse, even if you are seeking coverage only for yourself.)

SECTION 5 Certification (Important – please read carefully)

By signing this certification of eligibility, I certify under penalty of perjury that all statements contained in this certification are true. I further certify that I am ineligible for Medicare and I am not currently receiving continuation assistance through a COBRA subsidy program pursuant to the NYS Public Health Law.

I acknowledge that I will lose eligibility for this premium assistance if I should become eligible for Medicare or should move outside the state of New York, and will notify the NYS Continuation Assistance Program accordingly. I hereby acknowledge that if I am awarded continuance assistance and later become eligible for health insurance coverage through another union or an employer, I will no longer be eligible to receive continuation assistance through this program and the NYS Continuation Assistance Program may seek to recover any assistance provided to me after the date I became eligible for such health insurance coverage.

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.

Signature _____

Date _____

Send this application to:

**The NYS Continuation Assistance Program
NYS Department of Financial Services
P.O. Box 7184
Albany, NY 12224-0184**