

**FOR EMPLOYER OR PLAN USE ONLY**

This request is:  Approved  Denied Specify reason in #3 below and return a copy of this form to the applicant.

**REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. Individual did not experience a reduction in hours.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.	<input type="checkbox"/>
4. Individual has exhausted his COBRA coverage period.	<input type="checkbox"/>

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ \_\_\_\_\_ Date → \_\_\_\_\_

Type or print name → \_\_\_\_\_

Telephone number → \_\_\_\_\_ E-mail address → \_\_\_\_\_