

Department of the Treasury – Division of Pensions and Benefits  
**STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**

**COBRA SUBSIDY ROSTER**

Name of Employer: \_\_\_\_\_ SHBP/SEHBP Identification Number: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Certifying Officer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature of Certifying Officer: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Last Known Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Termination Date: \_\_\_\_\_ Termination Reason: \_\_\_\_\_

Was Employee Terminated for Misconduct? No  Yes

Does the Employer pay any portion of the COBRA Premium? No  Yes  *If yes give dollar amount or percentage:* \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Last Known Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Termination Date: \_\_\_\_\_ Termination Reason: \_\_\_\_\_

Was Employee Terminated for Misconduct? No  Yes

Does the Employer pay any portion of the COBRA Premium? No  Yes  *If yes give dollar amount or percentage:* \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Last Known Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Termination Date: \_\_\_\_\_ Termination Reason: \_\_\_\_\_

Was Employee Terminated for Misconduct? No  Yes

Does the Employer pay any portion of the COBRA Premium? No  Yes  *If yes give dollar amount or percentage:* \_\_\_\_\_

**Please return this completed roster to the Division of Pensions and Benefits no later than March 31, 2009**

To list additional involuntarily employees use a copy of this form.

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**STATE HEALTH BENEFITS PROGRAM AND SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM**  
**COBRA SUBSIDY ROSTER**

The federal American Recovery and Reinvestment Act (ARRA) of 2009 provides for a subsidy of COBRA premiums and/or a “second chance” for COBRA enrollment to individuals who were *involuntarily* terminated from employment after September 1, 2008. In order to identify these individuals and implement the provisions of the law, the Health Benefits Bureau of the Division of Pensions and Benefits requests employers to identify *involuntarily* terminated employees who may qualify under the ARRA.

**INSTRUCTIONS**

- Enter the employing entity’s SHBP or SEHBP identifying information requested on the form.
- List each employee who was *involuntarily* terminated since September 1, 2008 and provide the last known address for each employee.
- For each employee, indicate the reason for termination.
- For each employee, indicate if the employing entity pays *any part* of the former employee’s COBRA premium. If it does, indicate the dollar amount or the percentage paid.
- List all *involuntarily* terminated employees. If necessary, use additional copies of the form — number each page and the total number of pages at the lower right.

**Return the completed roster(s) to the Division of Pensions and Benefits no later than March 31, 2009.**

**HEALTH BENEFITS BUREAU  
DIVISION OF PENSIONS AND BENEFITS  
PO BOX 299  
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