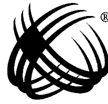

MEDICAL MUTUAL OF OHIO®
YOUR HEALTHCARE PARTNER SINCE 1934

Premium Remittance Form

If you are submitting less than 100 percent of your invoice amount for certain individuals continuing coverage under state continuation requirements who are eligible for the premium subsidy set forth in the American Recovery and Reinvestment Act of 2009 (ARRA), please complete this form. **This form must be signed by an authorized officer of the company who is responsible for payroll and other tax matters**.

I certify that the member(s) listed below were involuntarily terminated from employment after September 1, 2008, meet all of the state continuation provisions, have timely elected to continue coverage under those state provisions, and qualify for a premium reduction of 65 percent of the premium charged to the former employee.

Per ARRA, subsidy cannot exceed 65 percent of the net monthly premium remaining after any employer contribution.

Member Name	Member SSN	State Continuation Effective Date	Employer Contribution (if any)	Employee Payment	Subsidy to Be Claimed	Projected Subsidy End Date

Group Number ______________________

Invoice Number ______________________

Coverage Period ______________________

Group Official Name/Title ______________________

Group Official Signature ______________________ Date ____________

A signed and completed form must be submitted monthly with each premium payment when a subsidy is claimed.

Please mail form, along with premium payment to:

Medical Mutual of Ohio
P.O. Box 951922
Cleveland, OH 44193-0021

Office Use Only

Total MMO____________

Total KAI ____________

Rep Int ____________

Date ____________