



Adjunct COBRA Enrollment

This Form must be returned within 60 days of the COBRA event.
Your completed Form must be accompanied by payment up-to-day

PSC -CUNY Welfare Fund

61 Broadway 15th Floor
New York, NY 10006
212-354-5230 fax 212-354-5363

Enrollee			
Last Name	_____	First Name	_____
Street Address	_____		
City	_____	State	_____ Zip Code _____
Social Security Number	_____		

Qualifying Event	Check one:	Date
Loss of Employee's Coverage by Termination or Reduction of Hours	<input type="checkbox"/>	_____
Spouse Loss of Coverage due to Divorce	<input type="checkbox"/>	_____
Spouse / Child Loss of Coverage due to Death of Employee	<input type="checkbox"/>	_____
Dependent Child Loss of Coverage due to Age	<input type="checkbox"/>	_____

Covered Dependents			
	<u>Name</u>	<u>Social Security Number</u>	<u>DOB</u>
Spouse	_____	- -	_____
Dependent Child	_____	- -	_____
Dependent Child	_____	- -	_____
Dependent Child	_____	- -	_____

Election of Coverage		Check ONE box Below. The <u>Monthly Premium</u> is listed beside the option. Your Carrier must remain the same as immediately prior to your COBRA eligibility.	
	<u>Individual</u>	<u>Family</u>	
HIP - Metropolitan New York	\$673.67	\$1,650.47	
Empire Blue Cross			
	<u>Individual</u>	<u>Family</u>	
Downstate I Bronx, Brooklyn, SI, Rockland & NJ	<input type="checkbox"/> \$748.53	<input type="checkbox"/> \$1,946.17	
Downstate II Manhattan, Queens, Nassau & Suffolk	<input type="checkbox"/> \$790.80	<input type="checkbox"/> \$2,056.07	
Upstate I (Contact Fund Office or pscunywf.org for service area)	<input type="checkbox"/> \$1,107.66	<input type="checkbox"/> \$2,876.18	
Upstate II Clinton, Essex & Fulton	<input type="checkbox"/> \$1,249.30	<input type="checkbox"/> \$3,244.11	
Mid-Hudson (Contact Fund Office or pscunywf.org for service area)	<input type="checkbox"/> \$775.20	<input type="checkbox"/> \$2,015.52	
Capital Albany, Rensselaer & Schenectady	<input type="checkbox"/> \$0.00	Call for rate	<input type="checkbox"/> \$0.00

I hereby request that I continue my health insurance coverage through exercise of my COBRA rights. I have fully read the enclosed information and agree to the terms. I understand that I will not be billed by the Fund and that my COBRA rights will be voided by failure to pay my premium on time.

Member's Signature

Date