



Adjunct COBRA Enrollment

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:
Loss of Employee's Coverage by Termination or Reduction of Hours	<input type="checkbox"/>
Spouse/ Domestic Partner Loss of Coverage due to Divorce/ Dissolution	<input type="checkbox"/>
Spouse/ Domestic Partner/ Child Loss of Coverage due to Death of Employee	<input type="checkbox"/>
Dependent Child Loss of Coverage due to Age / Schooling limit	<input type="checkbox"/>

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

Election of Coverage		Check ONE box Below. The <u>Monthly</u> Premium is listed beside the option. Your Carrier must remain the same as immediately prior to your COBRA eligibility.			
	<u>Individual</u>		<u>Family</u>		
		<u>Nov 07 - Feb 08</u>		<u>Nov 07 - Feb 08</u>	
<u>Metropolitan New York Area</u>	<input type="checkbox"/> HIP Prime	\$462.45	<input type="checkbox"/> HIP Prime	\$1,132.98	
	<input type="checkbox"/> Blue Cross HMO	\$464.85	<input type="checkbox"/> Blue Cross HMO	\$1,208.61	
<u>Resident of NJ or CT</u> <i>Outside Service Area --></i>	<input type="checkbox"/> Blue Cross HMO	\$464.85	<input type="checkbox"/> Blue Cross HMO	\$1,208.61	
	<input type="checkbox"/> Blue Cross EPO	\$688.96	<input type="checkbox"/> Blue Cross EPO	\$1,787.86	
<u>Mid-Hudson Service Area</u>	<input type="checkbox"/> Blue Cross HMO	\$510.68	<input type="checkbox"/> Blue Cross Direct	\$1,327.76	
<u>Albany Service Area</u>	<input type="checkbox"/> Blue Cross HMO	\$427.46	<input type="checkbox"/> Blue Cross Direct	\$1,111.39	

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

