# COBRA Continuation Enrollment

***This Form must be returned within 60 Days of the COBRA event .***
***Your completed Form must be accompanied by payment up to date.***

**PSC-CUNY Welfare Fund**
**61 Broadway 15th Floor**
**New York, NY 10006**

## Welfare Fund Member

**Last Name** _____ **First Name** _____

**Social Security Number** _____ **College** _____

## Qualifying COBRA Event

Check **ONE** box Below.

- ☐ **Loss of Employee's Coverage by Termination or Reduction of Hours**
- ☐ **Spouse / Domestic Partner Loss of Coverage due to Divorce / Dissolution**
- ☐ **Spouse / Domestic Partner / Child Loss of Coverage due to Death of Employee**
- ☐ **Dependent Child Loss of Coverage due to Age**

## Applicant(s) for COBRA

| | Name | Social Security Number | Date of Birth |
|---|---|---|---|
| **Member** | | - - | / / |
| **Spouse/Domestic Partner** | | - - | / / |
| **Dependent Child** | | - - | / / |
| **Dependent Child** | | - - | / / |
| **Dependent Child** | | - - | / / |

## Applicant Contact Information

**Street Address** _____ **Telephone** _____

**City** _____ **State** _____ **Zip Code** _____

## Election of Coverage

Check **ONE** box below. Your basic Health Insurance determines your Welfare Fund COBRA premium.
Your Carrier must remain the same as immediately prior to your COBRA eligibility.
This Form **does not enroll you in your basic Health Insurance COBRA.**
Rates are 50% higher for persons who are totally disabled

**Core Coverage** *[Includes Prescription Drugs, Hearing Aids and Extended Medical (for GHI enrollees only)]*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Individual* | ☐ | GHI-CBP | $48.63 | ☐ All Others | $47.08 | ☐ Basic Waived | $5.02 |
| *Family* | ☐ | GHI-CBP | $131.35 | ☐ All Others | $127.16 | ☐ Basic Waived | $13.55 |

**Full Coverage** *Core Coverage plus Dental (Guardian or Delta) and Optical*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Individual (Guardian)* | ☐ | GHI-CBP | $70.64 | ☐ All Others | $69.08 | ☐ Basic Waived | $27.20 |
| *Individual (Delta)* | ☐ | GHI-CBP | $67.64 | ☐ All Others | $66.09 | ☐ Basic Waived | $24.20 |
| *Family (Guardian)* | ☐ | GHI-CBP | $190.75 | ☐ All Others | $186.57 | ☐ Basic Waived | $73.49 |
| *Family (Delta)* | ☐ | GHI-CBP | $174.40 | ☐ All Others | $170.22 | ☐ Basic Waived | $57.14 |

I hereby request that I continue my Welfare Fund coverage through exercise of my COBRA rights. I have fully read the enclosed information and agree to the terms and benefits. 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.

_____ _____
Applicant Signature Date