

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. Please make check payable to <u>PSC-CUNY Welfare Fund</u> and mail to:

PSC-CUNY Welfare Fund P.O. Box 23565 New York, NY 10087-3565

| | | | <u> </u> | 11 10007-3303 | | |
|--|--|---|--|--|--|----------------------------------|
| Welfare Fund Member Last Name | | | | First Name | | |
| Social Security Number | | | | First Name College | | |
| Obolar ocounty Hamber | - | | | | | |
| Qualifying COBRA Ever | nt | Check | ONE box Below. | | | |
| Loss of Employee's Coverage | by Termination of | or Reduction of I | Hours | | | |
| Spouse / Domestic Partner Lo | ss of Coverage | due to Divorce / I | 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 | | | | | | |
| | | <u>Name</u> | | Social Security | / Number | Date of Birth |
| Member | | | | <u> </u> | - | |
| Spouse/Domestic Partner | | | | - | - | |
| Dependent Child | | | | - | | |
| Dependent Child | | | | | - | / / |
| Dependent Child | | | | - | - | |
| | | | - | | | |
| Applicant Contact Infor | mation | | <u> </u> | | | |
| Applicant Contact Information Street Address | mation | | | Telephone | | |
| | mation | | | Telephone State | Zip Code | |
| Street Address City | | a annallad in COR | DA Rasin Hoalth Inc. | State | · · · · · | Fund CORPA promium |
| Street Address | You must be Your Carr | riers must rema | ain the same as ir | State | nes your Welfare | Fund COBRA premium. eligibility. |
| Street Address City Election of Coverage | You must be Your Carr This Form | riers must rema does not enro | ain the same as ir oll you in your ba | Stateurance, which determinediately prior to sic Health Insural | nes your Welfare | · · |
| Street Address City | You must be Your Carr This Form Rates are 50 | riers must rema does not enro higher for person | ain the same as ir bll you in your ba s who are totally disabl | Stateurance, which determinediately prior to sic Health Insural | nes your Welfare your COBRA | · · |
| Street Address City Election of Coverage Check ONE box below. | You must be Your Carr This Form Rates are 50 | riers must remain does not enro % higher for person eription Drugs and | ain the same as ir bll you in your ba s who are totally disabl | State | nes your Welfare your COBRA | · · |
| Street Address City Election of Coverage Check ONE box below. RX Coverage | You must be Your Carr This Form Rates are 50 | riers must remain does not enro % higher for person eription Drugs and | ain the same as ir bll you in your ba is who are totally disabl d Extended Medical | State | nes your Welfare your COBRA | · · |
| Street Address City Election of Coverage Check ONE box below. RX Coverage Individual | You must be Your Carr This Form Rates are 50 [Includes Presc GHI-CBP] | riers must remain does not enro % higher for person cription Drugs and \$46.42 \$125.47 | ain the same as in bil you in your bat is who are totally disable described Medical All Others | State Urance, which determined at the sic Health Insural led I (for GHI enrollees of \$41.20 | nes your Welfare your COBRA | eligibility. |
| Street Address City Election of Coverage Check ONE box below. RX Coverage Individual Family | You must be Your Carr This Form Rates are 50 [Includes Presc GHI-CBP] | riers must remain does not enro % higher for person cription Drugs and \$46.42 \$125.47 | ain the same as in bill you in your balls who are totally disable dextended Medical All Others All Others | State Urance, which determined at the sic Health Insural led I (for GHI enrollees of \$41.20 | nes your Welfare your COBRA nce COBRA. nly)] WAIVED (N Dental, Vision, | eligibility. |
| Street Address City Election of Coverage Check ONE box below. RX Coverage Individual Family Full Coverage | You must be Your Carr This Form Rates are 50 [Includes Presc GHI-CBP GHI-CBP | tiers must remain does not enro % higher for person ription Drugs and \$46.42 \$125.47 | ain the same as in bill you in your bates who are totally disabled Extended Medical All Others All Others All Others | State urance, which determinediately prior to sic Health Insurated I (for GHI enrollees of \$41.20 \$111.31 | nes your Welfare your COBRA nce COBRA. nly)] | lo RX) |
| Street Address City Election of Coverage Check ONE box below. RX Coverage Individual Family Full Coverage Individual (Guardian) | You must be Your Carr This Form Rates are 50 [Includes Presc GHI-CBP GHI-CBP RX Coverage p | does not enro h does not enro h higher for person tription Drugs and \$46.42 \$125.47 https://does.com/ | ain the same as in bill you in your bases who are totally disable described Medical All Others All Others All Others All Others All Others | State Urance, which determine the sic Health Insural led (for GHI enrollees of \$41.20) \$111.31 On and Hearing \$95.14 | nes your Welfare b your COBRA nce COBRA. nly)] WAIVED (N Dental, Vision, Hearing only Dental, Vision, Hearing only Dental, Vision, | lo RX) |
| Street Address City Election of Coverage Check ONE box below. RX Coverage Individual Family Full Coverage Individual (Guardian) Individual (Delta) | You must be Your Carr This Form Rates are 50 [Includes Presc GHI-CBP RX Coverage p GHI-CBP GHI-CBP GHI-CBP | tiers must remain does not enro Modes not enro higher for person tription Drugs and \$46.42 \$125.47 Substitute Dental (Guar \$100.38 \$70.62 | ain the same as in bill you in your bates who are totally disabled Extended Medical All Others | State urance, which determine the sic Health Insurance of | nes your Welfare your COBRA nce COBRA. nly)] WAIVED (N Dental, Vision, Hearing only Dental, Vision, Hearing only | lo RX) \$62.46 \$32.71 |