



# 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 PSC-CUNY Welfare Fund and mail to:*

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

<b>Welfare Fund Member</b>	
Last Name _____	First Name _____
Social Security Number _____	College _____

<b>Qualifying COBRA Event</b>	Check <u>ONE</u> box Below.
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	<input type="checkbox"/>

<b>Applicant(s) for COBRA</b>			
	<u>Name</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
Member	_____	- - _____	/ / _____
Spouse/Domestic Partner	_____	- - _____	/ / _____
Dependent Child	_____	- - _____	/ / _____
Dependent Child	_____	- - _____	/ / _____
Dependent Child	_____	- - _____	/ / _____

<b>Applicant Contact Information</b>			
Email Address	_____	Telephone	_____
Street Address	_____		_____
City	_____	State	Zip Code _____

<b>Election of Coverage</b>		You must be enrolled in COBRA Basic Health Insurance, which determines your Welfare Fund COBRA premium. Your Carriers must remain the same as immediately prior to your COBRA eligibility. This Form <b>does not enroll you in your basic Health Insurance COBRA.</b>	
Check <u>ONE</u> box below.		Rates are 50% higher for persons who are totally disabled	
<b><u>RX Coverage ONLY</u></b>		<b>Prescription coverage only. No Dental, Optical or Hearing</b>	
	<input type="checkbox"/> Individual \$46.00	<input type="checkbox"/> Family \$124.28	
<b><u>Full Coverage</u></b>		<b>RX Coverage plus Dental (Guardian or Delta), Vision and Hearing</b>	
Individual	<input type="checkbox"/> Guardian \$102.01	<input type="checkbox"/> Delta \$71.12	
Family	<input type="checkbox"/> Guardian \$270.62	<input type="checkbox"/> Delta \$183.81	
<b><u>Waived (No RX)</u></b>		<b>Dental (Guardian or Delta), Vision, Hearing only.</b>	
Individual	<input type="checkbox"/> Guardian \$64.92	<input type="checkbox"/> Delta \$34.04	
Family	<input type="checkbox"/> Guardian \$170.48	<input type="checkbox"/> Delta \$83.68	

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. The above monthly premiums are due on the first of every month.

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_