



Adjunct COBRA Enrollment

Assistance Eligible Individual Application

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 Circumstances		<i>Each Box must be checked as "Yes"</i>	Yes
Loss of Coverage by Employee's Involuntary Termination	<input type="checkbox"/>	On this Date:	Date _____
I am not eligible for any other Group Health Insurance Plan	<input type="checkbox"/>		
I am not eligible for Medicare	<input type="checkbox"/>		
<i>Check one Box</i>			
I am	<input type="checkbox"/>	Currently Enrolled in COBRA	<input type="checkbox"/>
		Enrolling with this Application as of :	Date _____

Covered Dependents			
	<u>Name</u>	<u>Social Security Number</u>	<u>Date of Birth</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>		
Metropolitan New York Area	<input type="checkbox"/>	HIP Prime	\$175.85	<input type="checkbox"/>	HIP Prime \$430.83
	<input type="checkbox"/>	Blue Cross HMO	\$188.04	<input type="checkbox"/>	Blue Cross HMO \$488.90
Resident of NJ or CT	<input type="checkbox"/>	Blue Cross HMO	\$188.04	<input type="checkbox"/>	Blue Cross HMO \$488.90
	<input type="checkbox"/>	Blue Cross EPO	\$238.47	<input type="checkbox"/>	Blue Cross EPO \$618.59
Outside Service Area -->	<input type="checkbox"/>	Blue Cross EPO	\$238.47	<input type="checkbox"/>	Blue Cross EPO \$618.59
Mid-Hudson Service Area	<input type="checkbox"/>	Blue Cross HMO	\$206.44	<input type="checkbox"/>	Blue Cross Direct \$536.73
Albany Service Area	<input type="checkbox"/>	Blue Cross HMO	\$173.02	<input type="checkbox"/>	Blue Cross Direct \$449.85

I certify that all statements made herein are true and accurate to the best of my knowledge.
 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 _____

I certify that this individual qualifies as assistance eligible though involuntary termination on the date indicated above.

Signature: Authorized CUNY Representative _____ Position _____ Date _____