ADJUNCT 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 ADJUNCT Member

Last Name _____ **First Name** _____

Social Security Number _____ **College** _____

Qualifying ADJUNCT COBRA Event

Check **ONE** box Below.

- **Loss of Adjunct'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 ADJUNCT COBRA

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

ADJUNCT 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)
Family	☐ GHI-CBP ($131.35)	☐ All Others ($127.16)

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

Individual (Guardian)	☐ GHI-CBP ($70.64)	☐ All Others ($69.08)
Individual (Delta)	☐ GHI-CBP ($67.64)	☐ All Others ($66.09)
Family (Guardian)	☐ GHI-CBP ($190.75)	☐ All Others ($186.57)
Family (Delta)	☐ GHI-CBP ($174.40)	☐ All Others ($170.22)

I hereby request that I continue my Adjunct 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.

_____ _____
Adjunct Applicant Signature Date