



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 <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"/>

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		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 does not enroll you in your basic Health Insurance COBRA.							
Check ONE box below.		Rates are 50% higher for persons who are totally disabled							
RX Coverage	<i>[Includes Prescription Drugs and Extended Medical (for GHI enrollees only)]</i>								
<i>Individual</i>	<input type="checkbox"/> GHI-CBP \$41.90	<input type="checkbox"/> All Others \$40.43							
<i>Family</i>	<input type="checkbox"/> GHI-CBP \$113.19	<input type="checkbox"/> All Others \$109.22							
Full Coverage	<i>RX Coverage plus Dental (Guardian or Delta), Vision and Hearing</i>								
<i>Individual (Guardian)</i>	<input type="checkbox"/> GHI-CBP \$78.08	<input type="checkbox"/> All Others \$76.61	<table border="1"> <tr> <td colspan="2">WAIVED (No RX)</td> </tr> <tr> <td>Dental, Vision, Hearing only</td> <td>\$41.28 <input type="checkbox"/></td> </tr> <tr> <td>Dental, Vision, Hearing only</td> <td>\$26.30 <input type="checkbox"/></td> </tr> </table>	WAIVED (No RX)		Dental, Vision, Hearing only	\$41.28 <input type="checkbox"/>	Dental, Vision, Hearing only	\$26.30 <input type="checkbox"/>
WAIVED (No RX)									
Dental, Vision, Hearing only	\$41.28 <input type="checkbox"/>								
Dental, Vision, Hearing only	\$26.30 <input type="checkbox"/>								
<i>Individual (Delta)</i>	<input type="checkbox"/> GHI-CBP \$63.10	<input type="checkbox"/> All Others \$61.63							
<i>Family (Guardian)</i>	<input type="checkbox"/> GHI-CBP \$210.87	<input type="checkbox"/> All Others \$206.91	Dental, Vision, Hearing only \$111.51 <input type="checkbox"/>						
<i>Family (Delta)</i>	<input type="checkbox"/> GHI-CBP \$162.17	<input type="checkbox"/> All Others \$158.20	Dental, Vision, Hearing only \$62.80 <input type="checkbox"/>						

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