



# 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

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

<b>Qualifying ADJUNCT COBRA Event</b>	Check <u>ONE</u> box Below.
Loss of Adjunct'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 ADJUNCT COBRA</b>			
	<u>Name</u>	<u>Social Security Number</u>	<u>Date of Birth</u>
ADJUNCT Member	_____	- - _____	/ / _____
Spouse/Domestic Partner	_____	- - _____	/ / _____
Dependent Child	_____	- - _____	/ / _____
Dependent Child	_____	- - _____	/ / _____
Dependent Child	_____	- - _____	/ / _____

<b>ADJUNCT Applicant Contact Information</b>			
Street Address	_____	Telephone	_____
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> <u>Rates are 50% higher for persons who are totally disabled</u>	
Check one box below.		
<b>RX Coverage</b>	<i>[Includes Prescription Drugs and Extended Medical (for GHI enrollees only)]</i>	
Individual	<input type="checkbox"/> GHI-CBP \$43.34	<input type="checkbox"/> All Others \$41.95
Family	<input type="checkbox"/> GHI-CBP \$117.02	<input type="checkbox"/> All Others \$113.28
<b>Full Coverage</b>	<i>RX Coverage plus Dental (Guardian or Delta), Vision and Hearing</i>	
Individual (Guardian)	<input type="checkbox"/> GHI-CBP \$82.03	<input type="checkbox"/> All Others \$80.64
Individual (Delta)	<input type="checkbox"/> GHI-CBP \$64.70	<input type="checkbox"/> All Others \$63.31
Family (Guardian)	<input type="checkbox"/> GHI-CBP \$216.11	<input type="checkbox"/> All Others \$212.36
Family (Delta)	<input type="checkbox"/> GHI-CBP \$166.15	<input type="checkbox"/> All Others \$162.40

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