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

Welfare Fund Member

Last Name _____ **First Name** _____

Social Security Number _____ **College** _____

Qualifying COBRA Event

Check **ONE** box Below.

- **Loss of Employee'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 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 ***[Includes Prescription Drugs and Extended Medical (for GHI enrollees only)]***

Individual	☐ GHI-CBP	**$48.12**	☐ All Others	**$43.56**	
Family	☐ GHI-CBP	**$130.05**	☐ All Others	**$117.71**	

Full Coverage ***RX Coverage plus Dental (Guardian or Delta), Vision and Hearing***

					WAIVED (No RX)		
Individual (Guardian)	☐ GHI-CBP	**$100.01**	☐ All Others	**$95.44**	Dental, Vision, Hearing only	**$60.67**	☐
Individual (Delta)	☐ GHI-CBP	**$72.86**	☐ All Others	**$68.29**	Dental, Vision, Hearing only	**$33.52**	☐
Family (Guardian)	☐ GHI-CBP	**$265.24**	☐ All Others	**$252.90**	Dental, Vision, Hearing only	**$159.02**	☐
Family (Delta)	☐ GHI-CBP	**$188.52**	☐ All Others	**$176.17**	Dental, Vision, Hearing only	**$82.29**	☐

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 _____