

# Carpenters Health and Security Plan of Western Washington

## COBRA Application

### (18-Month Qualifying Event – Employee Health Plan)

- Please complete this application in its entirety.
- Enclose a check or money order made payable to “Carpenters Trusts of Western Washington.”
- Your completed application must be received within 60 days of the later of (1) termination of coverage under the Carpenters Health and Security Plan – For Employed Carpenters (the “Employed Plan”), or (2) the date this application was sent to you by the Trust Office. If your application is not sent to the Trust within this timeframe, you or your dependents whose coverage under this plan is terminating will not be entitled to COBRA Continuation Coverage.
- If your spouse or eligible children live at a separate address, please contact the Trust Office so that the Trust Office can send them a separate notice of their continuation rights.
- The Trust Office will notify you, in writing, of the acceptance or denial of your application.

#### Qualified Beneficiary Information

#### Date of Notice

<b>Name: Last, First, Middle</b>			<b>Member Number</b>	
<b>Home Address</b>	<b>Street</b>	<b>City</b>	<b>State Zip</b>	
<b>Telephone Number</b>	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			
( ) _____				

#### Entitlement to COBRA Continuation Coverage

As explained in the *General Notice of COBRA Continuation Coverage Rights* accompanying this application, coverage for you and your qualified beneficiaries may be extended under the Carpenters Health and Security Plan for a period not to exceed 18 months, including any months covered under Self-Contribution Coverage. This 18-month period may be extended to a period of up to 36 months for the affected qualified beneficiary (spouse or dependent child) if one of the 36-month qualifying events occurs after the 18-month COBRA Continuation Coverage period begins. However, in no event will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

#### Choice of Benefits and Monthly Amount

The initial payment must be made within 45 days from the date you elect COBRA Continuation Coverage (the application date). The initial payment covers the number of months from the date coverage would otherwise have terminated, including the month in which the initial payment is made. Thereafter, payments must be made monthly to continue coverage. Bills are mailed in the first week of the month for the following month’s coverage. Payment is due, in full, upon receipt of the bill but not later than 30 days from the beginning of the month to be covered. ***If you fail to make the initial payment, or any subsequent monthly payment, in a timely fashion, your coverage will terminate.***

You may elect COBRA Continuation Coverage for all covered family members, or each affected family member may decide independently whether to elect COBRA Continuation Coverage, including new qualified beneficiaries added while you are on COBRA Continuation Coverage. If you elect COBRA Continuation Coverage for yourself, you automatically elect coverage for your family members, unless you state otherwise. If you or an eligible family member do not elect COBRA Continuation Coverage in a timely manner, plan coverage will end and may not be reinstated.

If you elect COBRA Continuation Coverage, you are entitled to the coverage provided under the plan to similarly situated employees or family members. If you are enrolled in both a medical and dental plan, you have the right to elect medical coverage only. However, dental coverage cannot be reinstated later. In addition, life insurance benefits are not available under COBRA, and time loss benefits are not available for any disability that begins while you are covered under COBRA.

There are two options to choose from (check one only). If you elect to exclude dental benefits, these benefits cannot be reinstated later:

**Medical Benefits:** \$704.00 per month or \$247.00 per month with COBRA subsidy

**Medical and Dental Benefits:** \$821.00 per month or \$288.00 per month with COBRA subsidy

Is any family member covered by another medical, vision or dental plan?  Yes  No

If yes, please indicate the type of coverage, the name and social security number of the insured and the name and telephone number of the other insurance plan:

Name of Insured: \_\_\_\_\_

Name and Telephone Number of Insurance Company: \_\_\_\_\_

Type of Coverage: \_\_\_\_\_ SSN of Insured: \_\_\_\_\_

Are you (the participant) covered under the above coverage?  Yes  No If yes, when is the earliest it can be effective? \_\_\_\_\_

Are you (the participant) entitled to Medicare?  Yes  No

If you or an eligible dependent are covered by another plan or Medicare, the benefits of this plan are determined after the benefits of the other plan or Medicare.

**Important:** The accompanying *General Notice of COBRA Continuation Coverage Rights* explains in detail your rights and responsibilities under the Trust's COBRA Continuation of Coverage provisions. It provides additional information about the effect of your legal rights of not electing COBRA coverage, what alternative coverage (if any) is available from the Trust and your notification obligations. This includes how to obtain an 11-month extension of COBRA Continuation Coverage if you or an eligible family member are determined disabled by the Social Security Administration. This includes notifying the Trust Office within 60 days of receiving your Disability Determination. It also includes information about your responsibility to notify the Trust Office within 60 days if a second qualifying event occurs while you are on COBRA. All notices to the Trust Office must be in writing, identifying you, the eligible participant and be sent to the Trust Office at the following address:

Carpenters Trusts of Western Washington  
2200 Sixth Avenue, Suite 300  
Seattle, WA 98121-1839

## COBRA Continuation Coverage Election Agreement

I have read this application and the *General Notice of COBRA Continuation Coverage Rights* and understand my rights to elect COBRA Continuation Coverage. I understand that if I elect COBRA Continuation Coverage and I fail to make any payment on time, this coverage will terminate. I also agree to notify the Trust Office if I or any member of my family become covered under another group health plan or entitled to Medicare after the date of COBRA election. **Important:** COBRA is provided subject to your eligibility. The plan reserves the right to terminate your COBRA Continuation Coverage retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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