

Carpenters Health and Security Plan of Western Washington

COBRA Application

(36-Month Qualifying Event – Employed Plan)

- Please complete this application in its entirety and return it to the Trust Office. You must include a copy of your divorce decree or legal separation agreement, if applicable.
- 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 Plan, or (2) the date this application was sent to you by the Trust Office.
- 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.

Participant's Name: _____

Member Number: _____

Qualified Beneficiary Information

Date of Notice

Name: Last, First, Middle			Social Security Number	

Home Address	Street	City	State	Zip

Telephone Number			Date of Birth	
() _____			_____	
Eligible Dependents (List Dependent's Legal Name):			Date of Birth:	Relationship:

Entitlement To COBRA Continuation Coverage

As explained in the *General Notice of COBRA Continuation Coverage Rights* accompanying this application, you could be entitled to continue health coverage under the Carpenters Health and Security Plan – For Employed Carpenters for a period not to exceed 36 months from the date plan coverage would normally terminate due to one of the qualifying events below (please check **one** only):

- Your divorce or legal separation
- Your spouse's death.
- Dependent child loss of eligibility.

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 benefits cannot be reinstated later. In addition, life insurance benefits are not available 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
 Medical and dental benefits \$821.00 per month

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: _____

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* sets out in detail your eligible dependents rights and responsibilities under the Trust's COBRA continuation provisions. It provides additional information about the effect on their legal rights of not electing COBRA coverage, what alternative coverage (if any) is available from the Trust and their notification obligations. All notices to the Trust must be in writing, identify the person(s) electing continuation coverage, the eligible employee, the Trust's name 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 pay any premium payment on time, this coverage will terminate. I also agree to notify the Trust Office if I or any member of my family become(s) 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 of Qualified Beneficiary: _____ Date: _____