# TRANSPORT WORKERS UNION LOCAL 100

## Solidarity Fund Health Benefits Application & Agreement

____I wish to apply for benefits from the TWU Local 100 Solidarity Fund

Name_____

Address _____

PASS #_____ Department _____ Laid–off Date_____

Home Phone _____Cell Phone _____ E-Mail Address _____

I _____have or _____have NOT returned a form to the MTA stating that I wished to participate in the COBRA program.

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## Guidelines: As a condition of receipt of these benefits I agree to, and understand, the following:

• This benefit will last for six months only. If I am reimbursed for COBRA or insurance coverage already paid, that reimbursement will count against my six months.

• I understand that I must remain a member in good standing in order to receive benefits.

• I agree that I will notify Local 100 if I become re-employed and get health insurance coverage as a result of that re-employment.

• I understand that the COBRA payments will be paid directly to the carrier; only approved reimbursements will be paid to me (as long as I have documentation establishing my expenditure.

• I understand that the COBRA payments may be reduced to a level lower than the amount billed if the sums collected from the Local 100 members are insufficient to cover the costs. Should legal proceedings interfere with the collection of the Solidarity Fund assessment, I further understand that the union will not be liable for making COBRA payments after such interference.

• I understand that Local 100 has already received from the Authority the type of health benefits coverage that I had prior to my lay -off date and that the solidarity fund will only pay for cobra benefits of the same type and dollar amount.

• I understand that I am responsible for payment of any taxes that may result from receiving this benefit.

Signature: _____

Date:_____