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.

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

1. This benefit will last for six months or until the funds in the Solidarity Fund are exhausted. At that point I may not be eligible for any COBRA or COBRA like coverage since the Solidarity Fund is not my employer. If I am reimbursed for COBRA or insurance coverage already paid, that reimbursement will count against my six months.
2. I understand that I must remain a member in good standing in order to receive benefits.
3. 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.
4. Should legal proceedings interfere with the collection of the Solidarity Fund assessment, I understand that the union will not be liable for making COBRA or health benefit payments after such interference.
5. I authorize the NYC Transit Authority and my insurance carrier to share all of my medical records, to the fullest extent allowed under the law, with Local 100, Transport Workers Union, and or its Solidarity Fund
6. I understand that I am responsible for payment of any taxes that may result from receiving this benefit

Signature:_____**Date:**_____

(Please include this page when faxing)

Fax to Local 100

To:	**TWU Local 100 Solidarity**	**From:**	
Fax:	**212-724-5826**	**Date:**	
Phone :		**Pages:**	

PASS # _____

PRINT NAME# _____

The following are included in my fax:

- ☐ Solidarity Fund Health Benefits Application & Agreement