Transport Workers Union
of Greater New York AFL-CIO Local 100

COBRA Registration Form

Administered by Pro Benefits Administrators

Member or Dependent Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment /Unit #*

_____
City *State* *ZIP Code*

Phone Number: _____ SSN: _____

DOB: _____ BSCID: _____

Qualifying Event

Cobra offered for **18** *months for the following reasons*	*COBRA offered for* **36** *months for the following reasons*
Please check one:	*Please check one:*
☐ *Retirement*	☐ *Dependent reaches age 26 - Dental coverage*
☐ *Involuntary Term of Employment*	☐ *Dependent reaches age 19 and is enrolled as full-time student or if reaches age 23 - Vision coverage*
☐ *Voluntary Term of Employment*	☐ *Death of employee (please attach supporting documentation)*
☐ *Leave of Absence*	☐ *Divorce or Legal Separation*
☐ *Military Leave*	
☐ *FMLA*	
	Section above to be completed with Dependent Information
Date of Event	*Date of Event*

(The first of the following month will become the COBRA effective date)

COBRA EFFECTIVE DATE: _____

General information

A COBRA Packet will be mailed to address aboveapproximately one month prior to COBRA effective date (whenever possible)

COBRA is an extension of current elections; election changes only allowed during Open Enrollment

After enrolled: Coupons will be sent to address above for monthly COBRA premiums

Failure to make COBRA premium payments will result in termination of coverage

New dental and/or vision ID cards will be mailed; but old cards can still be used in the interim

Notes: _____

_____

Signature _____ *Date:*

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