



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

COBRA Registration Form

Administered by Dental Pay Plus

Member or Dependent Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment /Unit #

City State ZIP Code

Phone Number: _____ SSN: _____
(dependent/spouse only)

DOB: _____ BSC ID: _____

Qualifying Event

<i>Cobra offered for</i> <u>18 months</u> <i>for the</i> <i>following reasons</i> <i>Please check one:</i> ☐ Retirement ☐ Involuntary Term of Employment ☐ Voluntary Term of Employment ☐ Leave of Absence ☐ FMLA ☐ Military Leave-Premiums Paid by TWU Local 100	<i>COBRA offered for</i> <u>36 months</u> <i>for the</i> <i>following reasons</i> <i>Please check one:</i> ☐ Dependent reaches age 26 - Dental coverage ☐ Death of employee (please attach supporting documentation) ☐ Divorce or Legal Separation
<i>Date of Event</i>	<i>Date of Event</i>

(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 above approximately 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: _____