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

Cobra offered for ***18*** *months for the following reasons*

Please check one:

- ☐ *Retirement*
- ☐ *Involuntary Term of Employment*
- ☐ *Voluntary Term of Employment*
- ☐ *Leave of Absence*
- ☐ *FMLA*
- ☐ *Military Leave-Premiums Paid by TWU Local 100*

Date of Event _____

COBRA offered for ***36*** *months for the following reasons*

Please check one:

- ☐ *Dependent reaches age 26 - Dental coverage*
- ☐ *Death of employee (please attach supporting documentation)*
- ☐ *Divorce or Legal Separation*

Section above to be completed with Dependent Information

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 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:* _____

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