CITY OF NEW YORK EMPLOYEE BENEFITS PROGRAM

CONTINUATION OF COVERAGE APPLICATION

Date of Qualifying Event ____/____/____

REASON FOR SUBMISSION (PLEASE PRINT CLEARLY) (CHECK ONE)

☐ Termination of Employment/Member ☐ Reduction of Work Schedule ☐ Divorce or Legal Separation ☐ Termination of Domestic Partnership

☐ Death of Employee/Retiree ☐ Loss of Eligibility as a Dependent Child ☐ Transfer Plan (Transfer Period or Qualifying Event)

Present or former Contract Holder's Name: _____

Present or Former Health Plan: _____

Relationship to Present or Former Contract Holder } ☐ Self ☐ Spouse (former or current) ☐ Domestic Partner ☐ Son ☐ Daughter

Social Secruity Number: _____

Present or Former City Employee's Welfare Fund: _____

APPLICANT INFORMATION (PLEASE PRINT)

Last Name:	First Name:	M.I.:	Social Security Number:	Home Telephone #: ( )
Mailing Address:		Apt.:	Date of Birth:	Sex: ☐ Male ☐ Female
City:		State:		Zip Code:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Domestic Partner ☐ Legally Separated ☐ Divorced

Date of Marital Status Event ____/____/____

Is Applicant or Any Dependent Covered by Medicare? ☐ Yes ☐ No If Yes, a COPY of the Medicare Card MUST be attached.

FAMILY INFORMATION (PLEASE LIST ALL PERSONS TO BE COVERED, INCLUDING EMPLOYEE IF APPLICABLE (PLEASE PRINT)

First Name	Last Name	Social Security Number	Date of Birth	Check if Applicable: Relationship: Self	Spouse	Dom. Partner	Son	Daughter	Full Time Student	Perm-anently Disabled	Covered by Other Group Insurance

HEALTH PLAN REQUESTED (CHECK THE BOX BEFORE THE PLAN YOU WANT AND YOU MUST CHECK "YES OR NO" FOR THE OPTIONAL RIDER BENEFITS).

☐ Aetna HMO ☐ Cigna HealthCare ☐ DC 37 Med-Team ☐ Empire EPO - Nationwide ☐ Empire HMO - New York

☐ GHI-CBP/EBCBS ☐ GHI HMO ☐ HIP Prime HMO ☐ HIP Prime POS ☐ MetroPlus

☐ Vytra Health Plan OTHER _____

Optional Benefits: ☐ Yes ☐ No

WELFARE FUND - COBRA

Do you wish to purchase benefits from your welfare fund?

☐ Yes ☐ No

You must check "yes" to receive welfare fund benefits. A "no" response or not answering this questions will prevent you from receiving COBRA continuation benefits from your welfare fund. A copy of this form will be sent from the health plan to your welfare fund as proof that you have applied under COBRA for the City benefits. Before making this decision you should contact your welfare fund for available options and costs. You will pay the union welfare fund directly for the cost of these benefits. You may choose both the optional rider and the welfare benefits, either of these options or neither or these options.

AUTHORIZATION

I certify that the above information is correct. I fully understand that I am responsible for the full cost of my continuance of coverage and will be subject to the terms and condictions of the group contract.

_____ ____/____/____

Applicant's Signature Date

I choose to waive my rights to extend my current health coverage under COBRA. I wish to convert to a direct payment policy. Please send me a conversion contract.

_____ ____/____/____

Applicant's Signature Date

THIS NOTICE MUST BE MAILED DIRECTLY TO YOUR HEALTH PLAN
FOR COBRA CONTINUATION COVERAGE OR FOR DIRECT PAYMENT CONVERSION
(See Plan Description for address)