2009/2010 UAW/UMASS Health & Welfare Trust
COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after your loss of coverage date to decide whether you want to elect COBRA continuation coverage under the Plan. Send Election Form to: UAW/UMass Health & Welfare Trust Fund, 329 Middlesex House, 111 County Circle, Amherst, MA 01003.

This Election Form must be completed and returned by mail, fax or email attachment. If mailed, it must be post-marked no later than 60 days after your loss of coverage date; if by other means, it must be received no later than 60 days after your loss of coverage date.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form. Please read the important information about your rights included in your COBRA notice.

Enter enrollment information below (filling out all fields is required). **DO NOT SEND PAYMENT WITH THIS FORM.**

First Name: ___________________ Last Name: __________________________ Gender: ________

Address 1: ____________________ Address 2: ____________________ City: __________________

State: _____ Zip: __________ Phone: ____________________ Email: ______________________________

Social Sec #: _______________ UMass Student ID #: _____________ Date of Birth: mm /dd /yyyy

Month & Year of Graduation (place X in month) : ____ May ____ Sept ____ Feb 20____

Losing Coverage for other reason? ____ If Yes, Date of Loss of Coverage ____________

PLAN SELECTION: I (we) elect COBRA coverage in the UAW/UMass Health & Welfare Trust Fund Plan as indicated below:

Apply for **Delta Dental** PPO Plus Premier Plan? (please check the appropriate box below):

☐ Single $29.80/month ☐ Family $88.42/month ☐ Neither plan

Apply for **EyeMed Vision Plan**? (please check the appropriate box below):

☐ Single $6.60/month ☐ Single+1 other person $12.54/month ☐ Family $18.36 ☐ None of these

PLEASE LIST ANY PLAN DEPENDENTS for the above plans, IF APPLICABLE:

	First Name	Last Name	Date of Birth	Gender
Partner				
Children				

"I certify that all information submitted to the UAW/UMass Health & Welfare Trust is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership and benefits will be determined by my employer and/or the Trustees of the UAW/UMass Health & Welfare Trust and/or plan sponsor in accordance with the underwriting of any and all vendors employed by the Trust for the purpose of providing benefits.

I understand that by signing below, I'm agreeing to release to the administrative employees and Trustees of the UAW/UMass Health & Welfare Trust, to GEO/UAW Local 2322, and to any and all vendors employed by the Trust for the purpose of providing benefits, information necessary to provide me with, and to verify my eligibility for, any and all benefits offered by the Trust (including but not limited to dental, vision, wellness, EAP and childcare assistance).

Finally, I certify that the above benefits (please mark only one option in each column for dental, vision, and wellness) are those that I am applying for in plan year 2009-10:"

Subscriber Signature: ______________________________________ Date: ___________________

Partner/Spouse Signature: ______________________________________ Date: _______________

Child #1 Signature (parent should sign for minors): ______________________________________ Date: _______________

Child #2 Signature (parent should sign for minors): ______________________________________ Date: _______________

Child #3 Signature (parent should sign for minors): ______________________________________ Date: _______________

Child #4 Signature (parent should sign for minors): ______________________________________ Date: _______________

Return this form to: UAW/UMass Health & Welfare Trust, 111 County Circle, 329 Middlesex House, UMass Amherst 01003. *(rev Dec. 2009)*