District Council 37 Benefits Fund Trust

125 Barclay Street • New York, N.Y. 10007-2179 • (212) 815-1234

APPLICATION FOR CONTINUATION OF DC 37 HEALTH AND SECURITY PLAN
COBRA HEALTH–RELATED BENEFITS

APPLICANT INFORMATION (Please Print)

Last Name	First Name	M.I	Social Security #	Home Telephone # ( )

Mailing Address	Apt. #	Date of Birth / /	Sex: Male ☐ Female ☐

City	State	Zip	Marital Status	Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐

Reason for Submission:

☐ Death of Employee/Retiree - **Date:** _____
☐ Divorce or Separation - **Date:** _____
☐ Reduction of Work Schedule - **Date:** _____
☐ Loss of Eligibility – **Date:** _____
☐ Termination of Employment – **Date:** _____

Relationship To Member or Former Member ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Domestic Partner

Member or Former Member's Name Name _____ S.S. No. _____

SPOUSE/DOMESTIC PARTNER AND DEPENDENT CHILDREN APPLICATION

(To be completed only if spouse and/or dependents are to be covered under applicant's plan. List each eligible separately. List spouse only if currently married.)

First Name	Last Name (If different)	Social Security Number	Birth Date	Relationship: Spouse/ Domestic Partner	Son	Daughter	Check if applicable: Full Time Student	Permanently Disabled

COVERAGE ELECTION

☐ Individual
☐ Family

ALL BENEFITS

☐ With Drugs
☐ Without Drugs

OR

CORE BENEFITS ONLY ***(Excludes Dental & Vision)***

☐ With Drugs
☐ Without Drugs

Is applicant eligible for or covered by another group health policy?

☐ Yes
If yes, name of policy: _____

☐ No

Is applicant enrolled in:

Medicare Part A? ☐ Yes ☐ No
Medicare Part B? ☐ Yes ☐ No

Medicare Drug Plan? ☐ Yes ☐ No
If yes, name of drug plan: _____

I understand that I am responsible for the full premium for this coverage, the timely submission of payments and am subject to all the rules that govern the administration of these benefits. I further understand that the Plan's COBRA benefits do <u>not</u> include hospital or doctor coverage.

_____ Applicant's Signature

_____ Date

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