NECA-IBEW WELFARE TRUST FUND

ENROLLMENT FORM FOR COBRA CONTINUATION COVERAGE

(Qualified Beneficiary/Family)

READ THE ENCLOSED NOTICE BEFORE RESPONDING. YOU MUST RETURN THIS ENROLLMENT FORM EVEN IF YOU DO NOT WANT COBRA. MAIL THIS FORM TO:

NECA-IBEW Welfare Trust Fund
2120 Hubbard Avenue
Decatur, Illinois 62526-2871

FORM DUE BY: ____*[Enter Date]*_____. IF THE FORM IS NOT RETURNED, YOU WILL LOSE YOUR COBRA CONTINUATION RIGHTS. ANSWER ALL QUESTIONS ON THIS FORM. CONTACT THE FUND AT (800) 765-4239, IF YOU HAVE ANY QUESTIONS.

Name of Member: _____*[Enter]*_____**Social Security No.:** _____*[Enter]*_____

☐ WE UNDERSTAND THE CONTINUATION COVERAGE PROVISIONS AND ELECT COBRA. **THE MONTHLY PREMIUM IS $735.00.*** WE UNDERSTAND THAT FAILURE TO PAY THE MONTHLY AMOUNT AS EXPLAINED IN THE ATTACHED NOTICE WILL RESULT IN LOSS OF COVERAGE.

☐ OUR INITIAL PREMIUM PAYMENT IS ENCLOSED.

☐ WE UNDERSTAND THE CONTINUATION COVERAGE PROVISIONS AND DO NOT ELECT COBRA UNDER THE PLAN.

PLEASE NOTE: Print the names (including yours) and social security numbers of all individuals who would otherwise lose eligibility in the spaces below. If COBRA is rejected, all qualified beneficiaries have an independent right to elect COBRA on their own.

Name	Social Security No.

The name(s), address(es), and telephone number(s) of any spouse or dependent child not residing with me is as follows:

Name ____

*If you are entitled to an adjusted COBRA payment, see the enclosed adjustment sheet.