SCMEBF Continuation of Coverage Application

FOR USE WITH COBRA CONTINUATION COVERAGE

If you are a former member of the Benefit Fund and wish to continue coverage through COBRA, please complete the application below and return it to the Fund with your payment.
If the former employee is not electing COBRA continuation coverage and you are currently an eligible dependent of that member, you must fill in the name and Social Security number of the former employee that you were covered under.
For active employees and dependents COBRA coverage includes full dental, optical, prescription co-payment reimbursement and hearing aid benefit for the monthly premium of: **$44.94** for each individual enrolling in single coverage, **$89.88** for individual +1 or **$123.00** for family coverage. For dependents of a retiree, COBRA coverage includes optical, hearing aid, and retiree dental for a monthly premium of: **$17.55** for single coverage, **$35.07** for family coverage.

TYPE OR PRINT WITH BALL-POINT PEN

EMPLOYEE NAME		EMPLOYEE SS #	EMPLOYEE BENEFIT FUND #		ADMINISTRATIVE USE ONLY	
			BF00			
PRIMARY ENROLLEE NAME IF DIFFERENT FROM ABOVE OR SECONDARY ENROLLEE		ENROLLEE SS #	HOME PHONE ( )		COBRA EFFECTIVE DATE	COBRA PLAN
ADDRESS: STREET & NUMBER OR P.O. BOX	APT. NO.	CITY	STATE	ZIP		

PLEASE LIST ALL PERSONS TO BE ENROLLED				DATE OF BIRTH	SEX		SOCIAL SECURITY NUMBER
RELATIONSHIP	LAST NAME	FIRST	M.I.	MO DAY YEAR	M	F	

ELECTION TO CONTINUE OR DECLINE COVERAGE CONTINUATION		
EVENT DATE	TYPE OF EVENT	DURATION OF COVERAGE
	Employment separation or reduction in work hours	18 months
	Retirement	18 months
	Dependent is over 19 and not a full time student	36 months
	Divorce or legal separation	36 months
	Marriage of dependent or dependent turns age 25	36 months
	Death of employee	Indefinite

☐ **Decline Coverage:** I understand I will not be eligible to continue or re-start my coverage if the request to do so is declined.

☐ **Continue Coverage:** I understand my request to do so must be received at the address provided below within 60 days from the date of this Notice. I also understand I am fully responsible for the premium payment. Failure to pay the premium in a timely manner will result in the termination of my coverage.

Is anyone applying for continued coverage also covered by another group dental/optical or prescription care plan? ☐ Yes ☐ No **If yes, name of carrier** _____

☐ **I believe I will qualify for Retiree Benefits in accordance with the Benefit Fund Reference Guide eligilbily guidelines. Therefore, I, exercise my right to preserve my retiree benefits for when I become eligible by maintaining continous coverage from the date of my separation from employment until such time as I am in receipt of a NYS Retirement System Pension. I understand if I do not choose to continue my benefits under COBRA I will forfeit my retiree benefits at a later date.**

I have read and understand the statement of rights and conditions on the enclosed documentation. I hereby request continued coverage as indicated above. I understand failure to make timely payment of required self-pay charges will result in **permanent** loss of this coverage. I also understand each applicant must have been covered by the Benefit Fund at the time of the qualifying event, except for added family members as stated under "COBRA" in my benefit booklet. I agree to notify the Fund if any of the above persons obtain other coverage or changes to status after this coverage begins. This form supersedes all previous forms I have submitted.

Make Check Payable to and Return to:
Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, NY 11716-2513
(631) 319-4099

_____ **SIGNATURE**

_____ **DATE**

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