Carpenters Health and Security Plan of Western Washington

COBRA Application For 18-Month Qualifying Event

Eastern Washington, Idaho, Montana, Wyoming

- Please complete this application in its entirety.
- Enclose a check or money order made payable to "Carpenters Trusts of Western Washington."
- Your completed application must be received within 60 days of the later of (1) termination of coverage under the Carpenters Health and Security Plan, or (2) the date this application was sent to you by Carpenters Trusts. If your application is not sent to the Trust within this timeframe, you or your dependents whose coverage under this plan is terminating will not be entitled to COBRA Coverage.
- If your spouse or eligible children live at a separate address, please contact Carpenters Trusts so Carpenters Trusts can send them a separate notice of their continuation rights.
- Carpenters Trusts will notify you, in writing, of the acceptance or denial of your application.

Participant Information

Date of Notice: _____

Name: Last, First, Middle

Social Security Number

_____

Mailing Address Street City State Zip

_____

Telephone Number

Marital Status ☐ Single ☐ Married ☐ Divorced

( ) _____

Entitlement to COBRA Coverage

As explained in the *COBRA Coverage Election Notice* accompanying this application, coverage for you and your qualified beneficiaries may be extended under the Carpenters Health and Security Plan for a period not to exceed 18 months, including any months covered under Self-Contribution Coverage. This 18-month period may be extended to a period of up to 36 months for the affected qualified beneficiary (spouse or dependent child) if one of the 36-month qualifying events occurs after the 18-month COBRA Coverage period begins. However, in no event will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

Choice of Benefits and Monthly Amount

The initial payment must be made within 45 days from the date you elect COBRA Coverage (the application date). The initial payment covers the number of months from the date coverage would otherwise have terminated, including the month in which the initial payment is made. Thereafter, payments must be made monthly to continue coverage. Bills are mailed in the first week of the month for the following month's coverage. Payment is due, in full, upon receipt of the bill but not later than 30 days from the beginning of the month to be covered. **If you fail to make the initial payment, or any subsequent monthly payment, in a timely fashion, your coverage will terminate.**

You may elect COBRA Coverage for all covered family members, or each affected family member may decide independently whether to elect COBRA Coverage, including new qualified beneficiaries added while you are on COBRA Coverage. If you elect COBRA Coverage for yourself, you automatically elect coverage for your family members, unless you state otherwise. If you or an eligible family member do not elect COBRA Coverage in a timely manner, plan coverage will end and may not be reinstated.

(over, please)

If you elect COBRA Coverage, you are entitled to the coverage provided under the plan to similarly situated employees or family members. If you are enrolled in both a medical and dental plan, you have the right to elect medical coverage only. However, dental coverage cannot be reinstated later. In addition, life insurance benefits are not available under COBRA, and time loss benefits are not available for any disability that begins while you are covered under COBRA.

There are two options to choose from (check one only). The rates for 2018 are:

☐ **Medical Benefits:** $1,123/month

☐ **Medical and Dental Benefits:** $1,169/month

Is any family member covered by another medical, vision or dental plan? ☐ Yes ☐ No

If yes, please indicate the type of coverage, the name and social security number of the insured and the name and telephone number of the other insurance plan:

Name of Insured: _____ SSN of Insured: _____

Name and Telephone Number of Insurance Company: _____

Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Prescription ☐ Vision

Are you (the participant) covered under the above coverage? ☐ Yes ☐ No. If yes, when is the earliest it can be effective? _____

Are you (the participant) entitled to Medicare? ☐ Yes ☐ No

If you or an eligible dependent are covered by another plan or Medicare, the benefits of this plan are determined after the benefits of the other plan or Medicare.

Important: The accompanying *General Notice of COBRA Coverage Rights* explains in detail your rights and responsibilities under the Trust's COBRA Coverage provisions. It provides additional information about the effect of your legal rights of not electing COBRA Coverage, what alternative coverage (if any) is available from the Trust and your notification obligations. This includes how to obtain an 11-month extension of COBRA Coverage if you or an eligible family member are determined disabled by the Social Security Administration. It also includes information about your responsibility to notify Carpenters Trusts within 60 days if a second qualifying event occurs while you are on COBRA. All notices to Carpenters Trusts must be in writing, identifying you, the eligible participant, and must be sent to Carpenters Trusts at the following address:

Carpenters Trusts of Western Washington
2200 Sixth Avenue, Suite 300
Seattle, WA 98121-1839

COBRA Coverage Election Agreement

I have read this application and the *COBRA Coverage Election Notice* and understand my rights to elect COBRA Coverage. I understand that if I elect COBRA Coverage and I fail to make any payment on time, this coverage will terminate. I also agree to notify Carpenters Trusts if I or any member of my family become covered under another group health plan or entitled to Medicare after the date of COBRA election. **Important:** COBRA is provided subject to your eligibility. The plan reserves the right to terminate your COBRA Coverage retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Signature: _____ Date: _____