Northwest Carpenters Health and Security Plan

COBRA Application For 36-Month Qualifying Event

Western and Central Washington

- Please complete this application in its entirety and return it to Northwest Carpenters Trusts.
- Enclose a check or money order made payable to "Northwest Carpenters Trusts."
- Your completed application must be received within 60 days of the later of (1) termination of coverage under the Northwest Carpenters Health and Security Plan, or (2) the date this application was sent to you by Northwest Carpenters Trusts.
- Northwest Carpenters Trusts will notify you, in writing, of the acceptance or denial of your application.

Participant's Name **SSN**

Qualified Beneficiary Information **Date of Notice**

Name: Last, First, Middle Social Security Number

Mailing Address Street City State Zip

Telephone Number Date of Birth Marital Status ☐ Single ☐ Married ☐ Divorced

( ) _____

Entitlement to COBRA Coverage

As explained in the *COBRA Coverage Election Notice* accompanying this application, your coverage may be extended under the Northwest Carpenters Health and Security Plan for a period not to exceed 36 months from the date eligibility terminated due to your qualifying event.

☑ Your loss of dependent eligibility

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.**

If you elect COBRA Coverage, you are entitled to the coverage provided under the plan to similarly situated employees or family members. Life insurance benefits are not available under COBRA.

☑ **Medical Benefits:** $1,386/month

Are you 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: _____

(over, please)

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

Are you (the qualified beneficiary) 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 *COBRA Coverage Election Notice* 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. All notices to Northwest Carpenters Trusts must be in writing, identifying you, the eligible participant, and must be sent to Northwest Carpenters Trusts:

Northwest Carpenters Trusts
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 Northwest 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: _____