

**UNION CONSTRUCTION WORKERS  
HEALTH PLAN**

P.O. BOX 697

TOLEDO, OHIO 43697-0697  
TOLL FREE – OH., MI., IN., FL. 1-800-432-2924

TEL. 419-248-2401

DATE: \_\_\_\_\_

COBRA CONTINUATION REQUEST FORM

For Coverage Month Beginning: \_\_\_\_\_

- 1. Are you an active employee/participant receiving a termination notice due to low work hours and who has failed to make your regular self-payment on time?
- 2. Are you a former employee/participant receiving a termination notice and not eligible to make a regular self-payment because you have left the trade?
- 3. Are you an active employee or former employee who has not been making self-payments for eighteen or more continuous months, and who have either a spouse no longer a dependent due to divorce or a child no longer a dependent due to reaching age 19 or if a full-time student age 23?
- 4. Are you a dependent spouse or dependent child no longer eligible for coverage due to death of our employee/participant or reaching an age when dependent coverage is no longer available?
- 5. Are you an active/employee participant no longer eligible under a collective bargaining agreement or rules and regulations of the Board of Trustees?

If the answer to one of the above questions is yes, this is your official request for a COBRA Continuation Form, and we urge you to read pages 15, 16 and 17 in the Plan Booklet. You may be eligible to continue participation for a variable period not exceeding 36 months.

If you have misplaced your plan booklet (Summary Plan Description) they are available from the Fund Office or at the Union Hall.

The cost of the COBRA coverage is not the regular self-pay rates, but reflects the full cost of the Health Program based on our insurance carrier rates and the cost of administration.

These costs are adjusted at such times as the cost of the insurance contract changes.

**COBRA CONTINUATION REQUEST FORM  
PAGE 2**

Comprehensive Medical and Prescription Drug Only – (No Life, Accidental Death and Dismemberment or Disability)

Single Coverage	\$266.25
Family Coverage	\$532.50

PLAN A

Comprehensive Medical and Prescription Drug with Vision and Dental Plan – (No Life, Accidental Death and Dismemberment or Disability)

Single Coverage	\$283.05
Family Coverage	\$566.10

PLAN B

Comprehensive Medical Only – (No Life, Accidental Death and Dismemberment or Disability)

Single Coverage	\$253.35
Family Coverage	\$506.70

If you become eligible for and desire COBRA Continuation Coverage as an active employee/participant or as a dependent spouse or child of an active employee/participant, it is your responsibility to give a timely notice to the Board of Trustees through the Fund Office as provided for in the Plan Booklet, pages 15, 16, and 17.

If COBRA Continuation Coverage is desired for an eligible employee/participant or dependent, check the applicable box on the front of this notice and...

**RETURN THIS NOTICE COMPLETED BELOW:**

MEMBER NAME \_\_\_\_\_

MEMBER'S SOCIAL SECURITY NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

**IF ELIGIBLE, COBRA CONTINUATION COVERAGE IS DESIRED FOR:**

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NO. \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_