

Use this form to notify the AFTRA Health Fund that you are eligible for other group health plan coverage or Medicare.

AFTRA Health Fund

Participant Notification

PO Box 13681
Newark, NJ
07188-3681

PERSONAL INFORMATION

Name and Mailing Address (indicate if mailing address is for a business manager, agent or other authorized representative)

Telephone Number

E-mail Address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. (Important: If any dependents are also eligible, include their names below.)

Insert date you became eligible _____

I am eligible for Medicare.

Insert date you became eligible _____

IMPORTANT

If you fail to notify the Plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

