

# AFTRA Health Plan - COBRA Election Form

To elect COBRA continuation coverage for yourself and your eligible dependents, please complete this form and return it by mail to the **AFTRA Health Fund, P.O. Box 13681, Newark, NJ 07188-3681** postmarked no later than 60 days after the later of: 1) the loss of coverage date; or, 2) the date of this notice.

If you do not submit a completed Election Form by the due date, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage, you may change your mind as long as you notify AFTRA H&R and we receive your completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date AFTRA H&R receives your completed Election Form.

**Read the important information about your rights included in the pages after the Election Form.**

If you have any questions about this Election Form or your rights to COBRA continuation coverage, you should refer to your Health Plan Summary Plan Description (SPD), visit the AFTRA H&R Web site at [www.aftrahr.com](http://www.aftrahr.com), or contact the Participant Services department at (800) 562-4690.

Loss of Coverage Date: \_\_\_\_\_ Date of Notice: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
(only if different from Participant)

Address: \_\_\_\_\_ Phone No: \_\_\_\_\_

**Reason for Loss of Coverage:** *Please check only one qualifying event.*

- |   |  |
|---|--|
| <input type="checkbox"/> Insufficient Earnings                                      | <input type="checkbox"/> Termination of Employment                                       |
| <input type="checkbox"/> Divorce or Legal Separation<br><i>Indicate date: _____</i> | <input type="checkbox"/> Child's Loss of Dependent Status<br><i>Indicate date: _____</i> |
| <input type="checkbox"/> Participant's Death  |  |

## **COBRA Option Election - All Premiums Listed Below Are Monthly Rates**

Note: If you qualify for the premium reduction provided by the American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act 2010 (2010 DOD act) and the Temporary Extension Act of 2010, the amounts due are 35% of the full premiums for up to 15 months. The reduced premium amounts are in parentheses. See the enclosed "Summary of the COBRA Premium Reduction Provisions under ARRA" for details. *Please check only one.*

- |  |  |   |
|--|--|---|
| Elect  |  |   |
| <input type="checkbox"/> Individual - \$598.00                             |  | <b>(\$209.00 with the ARRA reduction)</b> |
| Elect  |  |   |
| <input type="checkbox"/> Individual with one Dependent - \$1,225.00        |  | <b>(\$429.00 with the ARRA reduction)</b> |
| Elect  |  |   |
| <input type="checkbox"/> Individual with 2 or more dependents - \$1,793.00 |  | <b>(\$628.00 with the ARRA reduction)</b> |

## Election Authorization

Please sign and date where indicated and mail this form to the address below postmarked no later than **60 days** after the loss of coverage date (see opposite). If this form is not postmarked within the **60 day** period, you will not receive continued health coverage. In any event, payment must be postmarked no later than **45 days** after this form is received by the New York AFTRA H&R office. No claim will be processed or paid by the Fund until the initial premium payment is received.

**AFTRA Health Fund  
P.O. Box 13681  
Newark, NJ 07188-3681**

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(Participant or Applicant's Signature)

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(Date)

**Dependents:** *Only list dependents if Family Coverage is selected.*

<u>Last Name, First Name, Middle Initial</u>	<u>Date of Birth</u>	<u>Relationship to Participant</u>	<u>Social Security No.</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current eligible dependents, if applicable, may be provided COBRA coverage only if they were covered under the AFTRA Health Plan on the day before the qualifying event occurred. However, any person who acquires a new dependent (spouse, newborn or adopted child, etc.) during a period of continued coverage may under certain circumstances elect coverage for that dependent. Refer to your Health Plan SPD, visit the AFTRA H&R Web site at [www.aftrahr.com](http://www.aftrahr.com), or contact the Participant Services department at 1-800-562-4690 for more details.

### **Important Notice for New York State Residents**

**In September 2004, Governor Pataki signed legislation creating the New York State Continuation Assistance Program. Since January 2005, this program has assisted entertainment industry employees with payment of their COBRA continuation premiums if they meet certain eligibility requirements. First, you must be a New York State resident. Second, you must satisfy the income limitation. For more information about all the eligibility requirements, please refer to the enclosed Instructions for Application to the Program. Please note that the New York State program is separate and distinct from the COBRA Premium Reduction assistance available through ARRA, which was effective February 17, 2009. If you think you are eligible for assistance under both programs, please contact the Participant Services department at 1-800-562-4690.**