UFCW Local 789 and St. Paul Food Employers Health Care Plan
3001 METRO DRIVE, SUITE 500 • BLOOMINGTON, MINNESOTA 55425
952-854-0795

Election to Continue Health Care Coverage Under COBRA

Your name _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Telephone Number (____)_____

Date Coverage Ends: _____ Employer: _____

Check Appropriate Box: ☐ FT Employee ☐ PT Employee ☐ Spouse ☐ Dependent

Social Security Disability Yes☐ No☐ Medicare A and B Yes☐ No☐ Date eligible _____

Please Complete the Following

If you are covering dependents in addition to yourself, complete the information below.

1. Last Name _____ First Name _____ Middle Initial____

   Social Security Number _____ Date of Birth _____ Relationship _____

   Social Security Disability Yes☐ No☐ Medicare A and B Yes☐ No☐ Date eligible _____

2. Last Name _____ First Name _____ Middle Initial____

   Social Security Number _____ Date of Birth _____ Relationship _____

   Social Security Disability Yes☐ No☐ Medicare A and B Yes☐ No☐ Date eligible _____

3. Last Name _____ First Name _____ Middle Initial____

   Social Security Number _____ Date of Birth _____ Relationship _____

   Social Security Disability Yes☐ No☐ Medicare A and B Yes☐ No☐ Date eligible _____

4. Last Name _____ First Name _____ Middle Initial____

   Social Security Number _____ Date of Birth _____ Relationship _____

   Social Security Disability Yes☐ No☐ Medicare A and B Yes☐ No☐ Date eligible _____

Over

Indicate the Type of Coverage You are Electing if you are a Part-Time Employee

**Part Time"	Current Rate	Effective May 1, 2010	If Eligible for AARA Subsidy: Current Rate	If Eligible for AARA Subsidy: Effective May 1, 2010
☐ Option #1 Base Core Benefits -Hospital, Medical, Surgical & Major Medical	$226.00	$250.00	$79.10	$87.50
☐ Option #2 Base Core Benefits plus Dental	$245.00	$270.00	$85.75	$94.50
☐ Option #3 Base Core Benefits plus Dental & Life	$246.00	$271.00	$86.75	$95.50

Indicate the Type of Coverage You are Electing if you are a Full-Time Employee

"Full Time"	Current Rate	Effective May 1, 2010	If Eligible for AARA Subsidy: Current Rate	If Eligible for AARA Subsidy: Effective May 1, 2010
☐ Option #1 Base Core Benefits -Hospital, Medical, Surgical & Major Medical	$563.00	$619.00	$197.05	$216.65
☐ Option #2 Base Core Benefits plus Vision & Dental	$643.00	$701.00	$225.05	$245.35
☐ Option #3 Base Core Benefits plus Vision, Dental & Life	$646.00	$706.00	$228.05	$250.35

Election to Continue Coverage

By signing, I acknowledge that I have read the continuation notice and hereby elect to continue coverage under COBRA. Based on my election, I will make the necessary monthly payments for coverage. I understand that failure to pay for continued coverage will result in loss of eligibility for coverage.

_____ _____

Enrollee Signature Date

_____ _____

Parent or Guardian (for dependent children) Date

Special Note Regarding Initial Payments

If you are electing continuation of coverage, the initial payment will be for the period beginning from the date coverage ends and extends through the month in which payment is actually made. Checks or money order should be made payable to: **UFCW Local #789 Health Care Plan**.