

**UFCW Local 1189 and St. Paul Food Employers  
Health Care Plan**

3001 Metro Drive - Suite 500 | Bloomington, MN 55425 | 952-854-0795 | 800-535-6373

**ELECTION TO CONTINUE HEALTH COVERAGE UNDER COBRA**

Name:	Social Security Number:
Address:	
Birth Date:	Phone Number:
Date Coverage Ends:	Employer:
Social Security Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare A and B: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Eligible: _____

**Please select the type of coverage you want (rates effective as of May 1, 2023):**

**\*\* PART TIME EMPLOYEES\*\***

- Medical, Dental, & Life ..... \$806.00 per month
- Medical & Dental ..... \$805.00 per month
- Medical Only ..... \$778.00 per month
- Life Only ..... \$13.00 per month

**\*\* FULL TIME EMPLOYEES\*\***

- Medical, Dental, Vision & Life ..... \$1,151.00 per month
- Medical, Dental & Vision ..... \$1,145.00 per month
- Medical Only ..... \$1,092.00 per month

***Reverse Side Must be Completed and Signed***

**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: \_\_\_\_\_

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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: \_\_\_\_\_

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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: \_\_\_\_\_

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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: \_\_\_\_\_

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You or your eligible dependent(s) **must notify the Fund Office** of your intent to continue coverage **within 60 days of receiving notice** that your coverage has lapsed by completing this election form and **returning it to the Fund office**. Your **first payment** is required no later than 45 days after the 60 day election period and will be retroactive to the date your coverage lapsed. Subsequent payments are due in the Fund office on the first day of the month for which you are making payment. If payment is not received within 30 days after the due date, your coverage will terminate as of the last day of the previous month and cannot be reinstated. **YOU WILL NOT BE BILLED AND COVERAGE CANNOT BE CHANGED AFTER THE INITIAL ELECTION**. You may continue coverage for 18 consecutive months from the date coverage would have otherwise ended.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_