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: ❑ Yes ❑ No	Medicare A and B: ❑ Yes ❑ No Date Eligible:_____

Please select the type of coverage you want (rates effective as of May 1, 2024):

** PART TIME EMPLOYEES**

❑ Medical, Dental, & Life	$826.00	per month
❑ Medical & Dental	$825.00	per month
❑ Medical Only	$801.00	per month
❑ Life Only	$13.00	per month

** FULL TIME EMPLOYEES**

❑ Medical, Dental, Vision & Life	$1,079.00	per month
❑ Medical, Dental & Vision	$1,073.00	per month
❑ Medical Only	$ 994.00	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:_____

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:_____