2022-2023 UAW/UMASS Health & Welfare Trust Fund
COBRA Continuation Coverage Election Form

To elect COBRA continuation coverage, complete and sign this Election Form (EF) and return via secure email that will be sent to you by request. Under federal law, you have 60 days after your loss of coverage date to elect COBRA continuation coverage under the Plan. This form must be received no later than 60 days after your loss of coverage date. If you don't submit a completed EF by the due date, you lose your right to elect COBRA continuation coverage. If you officially reject COBRA continuation coverage via this EF before the due date, you may change your mind as long as you furnish a subsequent completed EF before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage begins on the date you furnish the subsequent completed EF. Your COBRA rights are detailed at: **http://www.hwtrust.geouaw.org** To return this form, please request a secure email link by emailing uawdental@external.umass.edu Payment is not due with this form--once your coverage is processed, you will receive confirmation and invoices via the email address you supply below.

PLAN SELECTIONS: I/We elect COBRA coverage in the GEO or Postdoc Unit Health & Welfare Plan as indicated:

Altus Dental Plan (one plan selection per column)

___ Individual Dental: $29.87/month

___ Individual +1 Dental: $59.82/month

___ Family Dental: $102.67/month

___ Decline Dental

EyeMed Vision Select Plan (one plan selection per column)

___ Individual Vision: $4.00/month

___ Individual +1 Person Vision: $7.59/month

___ Family Vision: $11.15/month

___ Decline Vision

Rates include 2% COBRA administrative fee.

"I certify all information submitted to the UAW/UMass Health & Welfare Trust Fund (TF) is true and correct to the best of my knowledge. I understand the effective & termination date of my benefits will be determined by my employer and/or the Trustees of the TF and/or plan sponsor in accordance with the underwriting of any and all vendors employed by the TF for the purpose of providing benefits. I understand that by signing below, I'm agreeing to release to the administrative employees and Trustees of the TF, to GEO/PRO/UAW Local 2322, and to any and all vendors employed by the TF for the purpose of providing benefits, information necessary to provide me with, and to verify my eligibility for, any and all benefits offered by the TF (including but not limited to dental and vision). I understand I must have been eligible and enrolled in regular plan benefits prior to losing my eligible status in order to be subsequently eligible for COBRA continuation coverage. I understand that the email address I provide on this application will be used as the primary means of communication from the TF regarding all issues involving my benefits and COBRA rights & responsibilities. It is solely my responsibility to keep the TF apprised of my current and accurate email address.

I certify that I am applying for a COBRA extension of the above selected benefits for up to a maximum of 18 months. I understand I am responsible for paying my monthly COBRA premium via PayPal and that timely payments are a condition of maintaining coverage. I understand COBRA participants are required to use PayPal's automatic, recurring bill pay feature in order to make their payments and that automatic payments may be ended at any time by myself or the TF. Should I let my payments lapse, I am not guaranteed retroactive reinstatement. Should I elect to end my COBRA coverage prior to the 18 months I am eligible for, I agree to provide notice 15 calendar days prior to the end of the month in which I want to end my coverage. I agree to inform any and all dependents who are qualified COBRA beneficiaries under my plan of their status as qualified beneficiaries and of any early termination of benefits.

☐ By checking this box and entering my full name below, I authorize the TF to accept my COBRA application via electronic submission and agree that my entered name constitutes my electronic signature on this form. I understand that I am legally bound, obligated, and responsible by use of my electronic signature as much as I would be by my handwritten signature."

Printed Name _____

Subscriber Signature _____ **Date** _____
(this signature is on behalf of the subscriber and any and all qualified beneficiaries of the subscriber.

Please provide a non-UMass email address we can use to send your invoices _____

Current Mailing Address _____