



2009/2010 UAW/UMASS Health & Welfare Trust Form for Switching COBRA Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment, complete this form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options. Send completed form to: UAW/UMass Health & Welfare Trust Fund, 329 Middlesex House, 111 County Circle, Amherst, MA 01003. This form must be completed and returned by mail, fax or email attachment.

THIS IS NOT YOUR ELECTION NOTICE

YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR COBRA CONTINUATION COVERAGE.

Enter enrollment information below (filling out all fields is required). DO NOT SEND PAYMENT WITH THIS FORM.

First Name: _____ Last Name: _____ Gender: _____
 Address 1: _____ Address 2: _____ City: _____
 State: _____ Zip: _____ Phone: _____ Email: _____
 Social Sec #: _____ UMass Student ID #: _____ Date of Birth: mm /dd /yyyy
 Month & Year of Graduation (place X in month) : ____ May ____ Sept ____ Feb 20____
 Losing Coverage for other reason? ____ If Yes, Date of Loss of Coverage _____

PLAN SELECTION: I (we) would like to change the COBRA continuation coverage options in the UAW/UMass Health & Welfare Trust Fund Plan as indicated below:

New **Delta Dental** selection (please check the appropriate box below):
 Single \$29.80/month Family \$88.42/month Neither plan

New **EyeMed** selection (please check the appropriate box below):
 Single \$6.60/month Single+1 other person \$12.54/month Family \$18.36 None of these

PLEASE LIST ANY PLAN DEPENDENTS for the above plans, IF APPLICABLE:

	First Name	Last Name	Date of Birth	Gender
Partner				
Children				

"I certify that all information submitted to the UAW/UMass Health & Welfare Trust is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership and benefits will be determined by my employer and/or the Trustees of the UAW/UMass Health & Welfare Trust and/or plan sponsor in accordance with the underwriting of any and all vendors employed by the Trust 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 UAW/UMass Health & Welfare Trust, to GEO/UAW Local 2322, and to any and all vendors employed by the Trust 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 Trust (including but not limited to dental, vision, wellness, EAP and childcare assistance).

Finally, I certify that the above benefits (please mark only one option in each column for dental, vision, and wellness) are those that I am applying for in plan year 2009-10:"

Subscriber Signature: _____ Date: _____
 Partner/Spouse Signature: _____ Date: _____
 Child #1 Signature (parent should sign for minors): _____ Date: _____
 Child #2 Signature (parent should sign for minors): _____ Date: _____
 Child #3 Signature (parent should sign for minors): _____ Date: _____
 Child #4 Signature (parent should sign for minors): _____ Date: _____