



**Welfare Fund
of Local No. One, I.A.T.S.E.**

320 West 46th Street, 6th Floor • New York, NY 10036 • Tel (212)247-5225 • Fax (212)247-5227 • www.fundoneiatse.com

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law you have 60 days from the date of this notice or the termination of your coverage (whichever is later) to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage and the premium assistance within 60 days from the date of this notice or the termination of your coverage (whichever is later), you may be ineligible for the premium assistance under the ARP.

Send completed Election Form to:

**Welfare Fund of Local No. One, I.A.T.S.E.
320 West 46th Street, 6th Floor
New York, NY 10036**

or

By FAX: (212)247-5227

or

By Email: FundOffice@FundOneIATSE.com

This Election Form must be completed and returned to our office by mail, by fax, by email, or in person. If mailed, it must be post-marked no later than August 29, 2021.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the Welfare Fund of Local No. One, I.A.T.S.E. (the Plan) as indicated below:

Name	Date of Birth	Relationship to Participant	SSN
a. _____			
b. _____			
c. _____			

Signature

Date

Print Name

Relationship to individual(s) listed above

To apply for ARP Premium Assistance, complete this form and return it to your plan or employer. If you have not yet elected COBRA continuation coverage, you may send this form along with your Election Form. If you do not complete this form and return it within 60 days from the date of this notice or the termination of your coverage (whichever is later), you may be unable to receive the premium assistance.

If you are already enrolled in COBRA, you may send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to the Fund Office at 320 W. 46th St, New York, NY 10036, or by Fax to (212)247-5227, or by email to FundOffice@FundOneIATSE.com.

You may also want to read the important information about the rules for premium assistance included in the "Summary of the COBRA Premium Assistance Provisions Under the American Rescue Plan Act of 2021."

Welfare Fund of
Local No. One, IATSE

**REQUEST FOR TREATMENT AS AN ASSISTANCE
ELIGIBLE INDIVIDUAL**

320 W. 46th St,
New York, NY 10036

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming premium assistance).	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to ARP premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

FOR EMPLOYER OR PLAN USE ONLY

This request is: Approved Denied Specify reason in #3 below and return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. Individual did not experience a reduction in hours.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

6 Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272, or online at <https://www.askebsa.dol.gov/WebIntake>.

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → Date → _____

Type or print name → Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to ARP premium assistance. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → Date → _____

Type or print name → Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARP premium assistance. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → Date → _____

Type or print name → Relationship to employee → _____