



SCMEBF Continuation of Coverage Application

**PRE-PAYMENT
COVERAGE**

If you are a NEW member of the Benefit Fund and wish to PRE-PAY coverage through COBRA, please complete the application below and return it to the Fund with your payment. You must fill in the name and Social Security of you and **all** your covered dependents under the plan. Members or dependents who fail to supply the Fund with any social security number, WILL NOT be enrolled or eligible for benefits until they do.

The **monthly** premium: **Check Box for coverage type:** \$46.76 for Single coverage \$93.52 for Individual +1 \$126.72 for Family coverage

Date of Hire: _____ **Check Box for length of coverage:** 1 month 2 months 3 months

Payment (Select 1)	<input type="checkbox"/> Credit/Debit Card #: _____ CW: _____ Exp: _____ Amt: \$ _____
	<input type="checkbox"/> Check Check #: _____ Amt: \$ _____

TYPE OR PRINT WITH BALL-POINT PEN

EMPLOYEE NAME		EMPLOYEE SS #		EMPLOYEE BENEFIT FUND # BF00		ADMINISTRATIVE USE ONLY	
PRIMARY ENROLLEE NAME IF DIFFERENT FROM ABOVE		ENROLLEE SS #		HOME PHONE ()		COBRA EFFECTIVE DATE	COBRA PLAN
ADDRESS: STREET & NUMBER OR P.O. BOX		APT. NO.	CITY	STATE	ZIP		

PLEASE LIST ALL PERSONS TO BE ENROLLED				DATE OF BIRTH	SEX		SOCIAL SECURITY NUMBER
RELATIONSHIP	LAST NAME	FIRST	M.I.	MO DAY YEAR	M	F	

ELECTION TO CONTINUE OR DECLINE COVERAGE CONTINUATION		
EVENT DATE	TYPE OF EVENT	DURATION OF COVERAGE
	Pre-Payment During Waiting Period	1 -3 months
<input type="checkbox"/> Continue Coverage: I understand my request to do so must be received at the address provided below within 60 days from the date of this Notice. I also understand I am fully responsible for the premium payment. Failure to pay the premium in a timely manner will result in the termination of my coverage.		

Is anyone applying for continued coverage also covered by another group dental/optical or prescription care plan? Yes No **If yes, name of carrier** _____

SIGNATURE/DATE

Make Check Payable to and Return to:
Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, NY 11716-2513
(631) 319-4099