IBEW LOCAL 400 WELFARE FUND
PO BOX 1028
WEST TRENTON, NJ 08628
FAX 609-530-1331

Application for Retiree Medical Reimbursement
or
COBRA Reimbursement

(please print or type)

Section I – Personal Information

Name of Applicant___________________________________ Social Security#_____________________

Street Address____

City, State, Zip_______________________________________ _________________________________

Date of Birth_____/_____/_____ Telephone # ( ) ____

Section II–Benefit Requested *(check one)*

______ Retiree Medical Reimbursement – payable if you qualify for coverage under the IBEW Local Union 400 Welfare Plan as a retired employee and you have made all required contributions to maintain coverage. You are eligible to be reimbursed for the required retiree monthly contributions under the IBEW Local Union 400 Welfare Plan, up to the balance in your account. Retiree Medical Reimbursement IS not subject to tax.

I request reimbursement for the months of __________________, _________through _________________________, _____________.

______ COBRA Reimbursement - payable if you have qualified under COBRA for continued coverage under the IBEW Local Union 400 Welfare Plan OR to upgrade coverage from Tier II to Tier I. You are eligible to be reimbursed for the required monthly contributions for COBRA under the IBEW Local Union 400 Welfare Plan or the required annual payment to upgrade coverage from Tier II to Tier I, up to the balance in your account.
Supplemental Health Benefits are not subject to tax.

I request reimbursement of COBRA payments for the months of __________________, ________ through __________________, _________.

I request direct reimbursement to the IBEW Local 400 Welfare Fund of COBRA payments for the months of __________________, ________ through __________________, _________.

______ I request Tier I coverage Single $675.00___ Parent/Children $1012.50___ Family $1350.00__

______ I request Tier II coverage Single $506.25___ Parent/Children $759.38___ Family $1012.50__

Section III – Signature

_____________________________________ ____________________
(Signature of Applicant) (Date)