CWA MEMBER REQUEST FOR COBRA PAYMENT

CWA members with chronic and serious ongoing medical conditions may be eligible for union-paid COBRA benefit payments. If you think you qualify for union-paid COBRA, fill out this form and submit it to your local Member Relief Fund Coordinator.

Part I.

1. Name: ________________________ Local: ____________________
2. Home Address: ____
3. Email: ________________________ Cell: ______________ Home phone: ______________
4. Total monthly household income including strike payments: $________________
5. Are you currently covered by a Verizon Health Care Plan? Yes No

   5a. If yes, what plan? ____

   5b. If yes, who in your family is covered under the plan? ________________________

Part II. To help us determine if you are eligible for union-paid COBRA benefits, please provide the following medical information.

6. Is insurance available through another member of your household? Yes No

   6a. If yes, have you requested coverage through that plan? Yes No

   6b. If you have not requested coverage, explain why: ________________________

   ____

7. Have you applied for any other medical coverage (Medicaid, etc.)? Yes No
8. Medical Information

Name	Age	Diagnosis

9. Prescription drugs being taken for serious condition

Condition	Medication/strength:	Monthly Cost

10. Pending appointments for treatment of serious, ongoing medical conditions

Family member/Patient name	Treatment	Cash payment

11. Physician(s) information

    Name: ______________________________

    Contact information: ______________________________

12. Please attach supporting documentation.

PART III. Determination

13. Reviewed by:

    Name: ____________________ Date: ______________

14. Recommendation:

    Union should pay COBRA Yes No

15. Signature of reviewer: ______________________________