Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage through the Health Fund.

Send this completed Election Form to:

Eligibility Department
Writers' Guild-Industry Health Fund
2900 W Alameda Ave Suite 1100
Burbank, CA 91505

This Election Form must be completed and returned by mail or fax no later than 60 days after your coverage ends.

If you do not submit a completed Election Form within 60 days of the date of this notice, 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 within the 60 day window. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form. Your payment is due within 45 of receipt of the date we received your election form, though you may submit payment with this form to expedite activation of your coverage.

_____ I (We) have read the above information and do not want to continue health coverage.

_____ I (We) have read the above information and want health coverage continued for the persons listed on this enrollment form.

_____
Writer's Name Date of Birth Unique ID#

_____
Or other eligible person electing COBRA Date of Birth

_____
Street Address City State Zip Code

Telephone (_____)_____ E-Mail Address _____

Check One: Single_____ Married_____ Separated _____ Divorced _____ Widowed _____

Are you or your spouse covered by Medicare? Yes___ No_____
If yes, check the appropriate space and submit a copy of your/their Medicare ID card. Self___ Spouse____

YOUR COBRA PLAN WILL BE SECONDARY TO MEDICARE.

List all persons (including yourself) to be covered under the COBRA continuation health coverage provided by the Writers' Guild - Industry Health Fund. Only persons listed below will be covered, provided they meet the eligibility requirements for this coverage, as set forth in this material. (If you need more space, you may use another sheet of paper.)

1. _____
(Writer- only if electing coverage) Date of Birth Other Insurance? Yes/no

2. _____
(Spouse) Date of Birth Other Insurance? Yes/no

3. _____
(Dependent) Date of Birth Other Insurance? Yes/no

4. _____
(Dependent) Date of Birth Other Insurance? Yes/no

5. _____
(Dependent) Date of Birth Other Insurance? Yes/no

_____ _____
Signature of writer or person electing (over age 18) Date

PLEASE REFER TO THE ENCLOSED COBRA SCHEDULE
FOR MONTHLY RATES

IMPORTANT CHECK ONE:

_____ Plan C/RC Regular PPO Medical/Hospital, RX, Vision, Wellness, Delta Dental (DPO)

_____ Plan B/RB Regular PPO Medical/Hospital, RX, Vision, Wellness (no Dental)

_____ Plan CU/RU Regular PPO Medical/Hospital, RX, Vision, Wellness, Delta Care (DMO)**

**For individuals who reside in California only. If you choose Plan CU, contact the Fund office immediately to request the directory and enrollment form.

_____ Plan L/RL Low-Option Medical & Hospital Only

**This plan has a $750 deductible and does not include Dental, RX, Vision, Wellness, or Life Insurance

Important information for New York State Residents: If you are a resident of New York State and would like to apply for their assistance program please contact the Albany Health Bureau of the New York State Department of Insurance at (518) 473-6107 or visit the website at: http://www.ins.state.ny.us/cobra/cobra_entertainmet.htm

WRITERS' GUILD-INDUSTRY HEALTH FUND – REGULAR COBRA MONTHLY RATES APRIL 1, 2018 THROUGH MARCH 31, 2019			
	Single	Two-Party	Family
Plan C - Regular Medical/Hospital, Delta Dental (DPO), Rx, Vision, Wellness	$856.00	$1,693.11	$2,298.30
Plan B - Regular Medical/Hospital, Rx, Vision, Wellness (no dental)	$802.12	$1,588.79	$2,157.53
*Plan CU - Regular Medical, Delta Care Dental (HMO), Rx, Vision, Wellness	$870.94	$1,626.29	$2,180.90
Plan L - Low Cost Medical/Hospital ONLY - $750 Deductible	$496.81	$980.73	$1,330.65
COBRA MONTHLY RATES FOR CHILDREN OR EX-SPOUSES OF RETIREES			
	Single	Two-Party	Family
Plan RC - (same as Plan C above)	$713.21	$1,406.10	$1,906.99
Plan RB - (same as Plan B above)	$650.76	$1,284.55	$1,742.73
Plan RU - (same as Plan CU above)	$713.86	$1,321.55	$1,767.71
Plan L - (same as Plan L above)	$539.38	$1,066.30	$1,477.22
*The CU plan is available to California residents only. If you are choosing the CU plan please contact the Eligibility Department and ask for the DeltaCare USA enrollment information.			

HOW TO LOCATE A BLUECARD® NETWORK PROVIDER

There are two ways you can find doctors and hospitals that participate in the PPO plan:

You may call at (800) 810-BLUE (2583) for assistance in finding a PPO physician or hospital. Be sure to tell the Customer Service Representative that your three digit alpha prefix is WRX.

You may also use our website, www.pwga.org, and click on the *Find Participating Provider* link to select a hospital network or physician in your area. Your ID# is 12 digits: a 3-digit alpha prefix (WRX) is followed by your unique ID# (A11413690). It is very important for your providers to use the entire 12 digit ID# on claims submission to *all medical and dental providers.* Please be sure to follow the claim submission information that is located on the back of your new ID card.