LABORERS'
BENEFITS • ST. LOUIS

Affidavit for Self-Payment

In order to continue coverage, this form must be fully completed each qualifying quarter.

1. Are you a member of Local 42 or 110? **Yes ○ No ○**

2. Are you available for work tomorrow with Local 42 or 110? **Yes ○ No ○**
   If no, please explain: _____

3. Are you currently working? **Yes ○ No ○**
   If yes, who are you working for? _____
   How long have you been working for them? _____

4. Do you have coverage through any other group policy? **Yes ○ No ○**
   If yes, provide policy name? _____

5. Are you retired? **Yes ○ No ○**

6. Are you on Workman's Compensation disability? **Yes ○ No ○**

7. Have you become totally and permanently disabled? **Yes ○ No ○**

8. Have you applied for Social Security Disability or a Disability Pension? **Yes ○ No ○**

If any of the above changes you must notify the Benefit Office.

I elect the following self payment coverage option:

○ Single ($100.00/Month or $300.00/Quarter) ○ Family ($150.00/Month or $450.00/Quarter)

You will not have insurance coverage until the Benefit Office receives the Self-Payment Affidavit and payment in our office. Payment must be received in our office and/or postmarked by the end of the current month in which the premium is due. (ex. January self-pay payment is due no later than January 31st.) Allow 48-72 hours before reinstatement of eligibility/benefits (not to include weekends).
We cannot accept cash however, we accept check, money order or credit card*. You may deliver or mail your check/money order to:

Construction Laborers' Welfare Fund
2357 59th Street, St. Louis, MO 63110

***Please note credit card payments will be subject to a 3% fee.**

Member Name: _____ Medical Member ID#: _____

Address, City, State, Zip: _____ Phone Number: _____

Email Address: _____ Local: _____

Member Signature: _____ Date: _____

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COBRA ELECTION FORM

If you do not meet the Self-Payment and/or exhaust Self-Payment options, you still have the option to elect the Consolidated Omnibus Budget Reconciliation Act ***"COBRA"*** continuation of coverage. ***COBRA*** benefits will continue to include the Medical, Dental, Hearing Aid, Vision Care Benefits, Member Assistance Program (MAP) and Prescription Drug program. ***COBRA*** continuation coverage ends 18 months from date of election or may be extended if you meet certain criteria as described under the continuation coverage extension section of the ***COBRA*** notice.

If you choose to elect ***COBRA*** continuation coverage, then this election form must be returned to our office within 60 days from the date of the qualifying event.

Select one category below and circle the rate. The monthly COBRA rates are as follows:

Category	COBRA Rates - Effective 1/1/2021	COBRA S.S. Award Disability Rates – Effective 1/1/2021
○ One Adult*	$538	$791
○ Two Adults*	$1,077	$1,584
○ One Adult & Child	$798	$1,174
○ One Adult & Children	$1,061	$1,560
○ Two Adults & Child	$1,336	$1,965
○ Two Adults & Children	$1,597	$2,349
○ Child	$261	$384
○ Children	$521	$766

***An adult is a member, spouse, ex-spouse or a child who is no longer a dependent as defined by the Plan.**

If you exercise your rights under the Plan to "Self-Pay," your ***COBRA*** continuation period will be reduced by the number of months during which you Self-Pay. Your continuation coverage period will also be reduced by the number of months for which you are granted a Disability extension. See Self-Pay provision and the Disability Extension Provision of the Plan set forth in Section 3:3 of the SPD.

I have read and understand the provisions of the ***COBRA*** Notice provided to me in the "Continuation Coverage Rights" which I have received. I am applying for the above ***COBRA*** continuation coverage if I am not eligible for Self-Payment and/or my Self-Payment options have been exhausted.

I understand I must pay ***COBRA*** premiums from the date my coverage terminates to the present within 45 days from the date I sign this ***COBRA*** continuation election form. This ***COBRA*** election form must be returned within 60 days of receipt. Premiums are due by the first day of the month. After that I must pay the required premium within 30 days following the first day of the month for which premium is due. We cannot accept cash however, we do accept check, money order or debit/credit card*. Any claims received may not be paid until ***COBRA*** payment is received in our office. I also understand the ***COBRA*** Premium rates may change at any time. I also understand that both myself and my spouse need to sign this form and if we do not, we are declining our individual ***COBRA*** rights.

We cannot accept cash however, we do accept check, money order or credit card. Please note credit cards are subject to a 3% fee.

I elect the following for COBRA continuation coverage:

○ Self ○ Spouse ○ Dependents (Please list): _____

Please list the current and/or previous contractor you are/were employed by: _____

Member Name: _____ Member ID#: _____

Address, City, State, Zip: _____ Phone Number: _____

Member Signature: _____ Spouse Signature: _____ Date: _____

Enclosure: General Notice of COBRA Continuation Coverage Rights