Minneapolis Retail Meat Cutters and Food Handlers
Health and Welfare Fund

3001 Metro Drive - Suite 500 | Bloomington, MN 55425 | 952-851-5797 | 844-468-5917

ELECTION TO CONTINUE HEALTH COVERAGE UNDER COBRA

Employee Name:	Employee Social Security Number:
Address:	
Employee Birth Date:	Phone Number:
Date Coverage Ends:	Employer:
Social Security Disability: ❑ Yes ❑ No	Medicare A and B: ❑ Yes ❑ No Date Eligible:_____

Please select the type of coverage you want to continue:

FULL TIME EMPLOYEES AND DEPENDENTS (If Applicable)

❑ Medical and Prescription, Dental, Vision & Life

❑ Medical and Prescription, Dental & Vision

❑ Medical and Prescription, & Life

❑ Medical and Prescription Only

❑ Dental, Vision & Life

❑ Life Only

MODIFIED PART TIME EMPLOYEES AND DEPENDENTS (If Applicable)

❑ Medical and Prescription, Dental, Vision & Life

❑ Medical and Prescription, Dental & Vision

❑ Medical and Prescription, & Life

❑ Medical and Prescription Only

❑ Dental, Vision & Life

❑ Life Only

ANCILLARY BENEFIT EMPLOYEES

❑ Dental, Vision & Life

❑ Life Only

Reverse Side Must be Completed and Signed

Please Complete the Following:

- **If you are covering dependents in addition to yourself, complete the information below.**

1. Last Name:_____ First Name:_____Middle Initial:_____

Social Security Number:_____Date of Birth:_____ Relationship:_____

Social Security Disability: ❑Yes ❑No Medicare A and B: ❑Yes ❑No Date eligible:_____

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2. Last Name:_____ First Name:_____Middle Initial:_____

Social Security Number:_____Date of Birth:_____ Relationship:_____

Social Security Disability: ❑Yes ❑No Medicare A and B: ❑Yes ❑No Date eligible:_____

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3. Last Name:_____ First Name:_____Middle Initial:_____

Social Security Number:_____Date of Birth:_____ Relationship:_____

Social Security Disability: ❑Yes ❑No Medicare A and B: ❑Yes ❑No Date eligible:_____

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4. Last Name:_____ First Name:_____Middle Initial:_____

Social Security Number:_____Date of Birth:_____ Relationship:_____

Social Security Disability: ❑Yes ❑No Medicare A and B: ❑Yes ❑No Date eligible:_____

- **If you are a dependent covering yourself only, complete the information below.**

Last Name:_____ First Name:_____Middle Initial:_____

Social Security Number:_____Date of Birth:_____ Relationship:_____

Social Security Disability: ❑Yes ❑No Medicare A and B: ❑Yes ❑No Date eligible:_____

You or your eligible dependent(s) **must notify the Fund Office** of your intent to continue coverage **within 60 days of receiving notice** that your coverage has lapsed by completing this election form and **returning it to the Fund office**. Your **first payment** is required no later than 45 days after the 60 day election period and will be retroactive to the date your coverage lapsed. Subsequent payments are due in the Fund office on the first day of the month for which you are making payment. If payment is not received within 30 days after the due date, your coverage will terminate as of the last day of the previous month and cannot be reinstated. ***YOU WILL NOT BE BILLED AND COVERAGE CANNOT BE CHANGED AFTER THE INITIAL ELECTION***. You may continue coverage for 18 consecutive months from the date coverage would have otherwise ended.

Applicant's Signature:_____Date:_____

Si usted tiene preguntas en cualquier momento en lo se refiere a este Plan, por favor llame a la Oficina del Fondo (952) 851-5797.

COBRA RATES (Monthly, effective May 1, 2026)

- For Employees Under Collective Bargaining Agreements with Tiered Rates:

Full-time and Modified Part-time Employees

	Employee Only	Employee + Spouse	Employee + Children	Family
Medical, Prescription, Dental, Vision & Life	$877.66	$1,705.94	$1,666.50	$2,810.32
Medical, Prescription, Dental, Vision	$872.82	$1,701.10	$1,661.66	$2,805.48
Medical, Prescription, & Life	$842.82	$1,637.17	$1,599.35	$2,696.30
Medical, Prescription	$837.98	$1,632.33	$1,594.50	$2,691.46
Dental, Vision & Life	$39.68	$73.61	$72.00	$118.86
Life	$4.84	$4.84	$4.84	$4.84

Ancillary Benefit Employees

	Employee Only
Dental, Vision & Life	$39.68
Life	$4.84

- For Employees Under Collective Bargaining Agreements with Composite Rates:

Full-time and Modified Part-time Employees

	Full-time Employee (and dependents)	Modified Part-time Employee (no dependent coverage)
Medical, Prescription, Dental, Vision & Life	$1,313.96	$877.66
Medical, Prescription, Dental, Vision	$1,309.11	$872.82
Medical, Prescription, & Life	$1,261.25	$842.82
Medical, Prescription	$1,256.40	$837.98
Dental, Vision & Life	$57.55	$39.68
Life	$4.84	$4.84

Ancillary Benefit Employees

	Employee Only
Dental, Vision & Life	$39.68
Life	$4.84