New England Health Care Employees
WELFARE FUND

77 Huyshope Avenue, 2nd Floor
Hartford, CT 06106-7001
860/728-1100 Fax 860/947-8080

WELCOME TO THE NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE FUND BENEFIT PLAN

Dear Participant:

Please find the enclosed necessary forms to enroll in the Welfare Fund. Included in your packet are the following:

- **Becoming a Participant in the Welfare Fund**
- **Instructions to filling out your Welfare and Pension Funds Enrollment Form**
- **Enrollment Form**
- **Coordination of Benefits (COB) Form **(needed only if you are adding dependents)***
- **How your Benefit Level Changes**
- **Benefit Coverage Chart**

In order to expedite your enrollment, you must fill out your forms completely and provide the Welfare Fund with the required documents as indicated on the "**Filling Out Your Welfare and Pension Funds Enrollment Form**" page. ***Failure to complete the forms or provide the Welfare Fund with the required documents will result in delaying your coverage.*** Your coverage does not begin until you enroll in the Fund.

Shortly after being enrolled in the Welfare Fund, you will receive the following:

- Summary Plan Description booklet (SPD)
- Medical ID cards
- Prescription cards (*sent directly from **EmpiRx Health***)
- Dental cards (*sent directly from **Delta Dental of NJ***)

If you have any questions about the Enrolment or COB form, please call the Membership Department at 860-728-1100 or 1-800-227-4744.

Becoming a Participant in the Welfare Fund

Who is Eligible? – You are eligible to participate in the Fund if you are an active employee who has completed the probationary period and your employer makes required contributions to the Fund on your behalf. Your employer pays 100% of the contributions to the Welfare Fund. *You make no contributions to the Welfare Fund.*

You are required to enroll in the Welfare Fund. To enroll in the Fund, you must get an Enrollment form from your Union organizer, your employer or by calling the Fund office.
Complete all sections of the form. Refer to "*Filling out your Welfare and Pension Fund Enrollment form below*"

Once all the eligibility and documented requirements have been met, your eligibility may be effective as early as the first day of the month following completion of your probationary period, depending on the terms of your Union contract. If you are an employee whose employer has recently become a contributing Fund employer, your coverage begins after you have enrolled in the Fund and your employer starts making contributions on your behalf as specified in the Union contract.

Filling Out Your WELFARE and PENSION Funds Enrollment form

Return your completed Enrollment Form to the Fund Office in the pre-addressed envelope provided or fax to 860-947-8080 within 60 days. The addition of a dependent to your coverage must be done within 31 days of the birth or adoption.

The Fund Office is currently receiving Employer contributions on your behalf. Employer contributions determine your eligibility for the Welfare Fund benefits and service credits in the Pension Fund.

The information that you provide on the enclosed Enrollment Form is necessary to ensure that you and your dependents are enrolled for health care benefits and that you receive the proper Pension credit. Claims for health care benefits will not be processed without a completed enrollment on file.

Please complete the enclosed enrollment form and return the form to the Fund Office as soon as possible.

- If you are eligible for **Welfare benefits**, please fill out **all sections**
- If you are **only** eligible for **Pension benefits,** please fill out sections 1, 2 and 3 and the signature section on page two.

How to Fill Out the Enrollment Form

Check ☑ the **New Enrollment** box

1. Complete your personal identification information (name, address, and social security number, telephone number, date of birth, sex, and marital status).
2. Complete your employment information (current employer, employer address, work telephone number, date of hire, hours per week, job classification, and if you have a second job with another 1199 employer provide the same information).

   List your previous Employment in the health care field.

3. Provide the name of your eligible spouse (husband, wife, or same-sex spouse), date of marriage, spouse's date of birth and social security number
   [As of January 1, 2021 your spouse will only be eligible if they do not have access to health coverage through their own employer, must enroll in the Funds Spousal Special Enrollment plan and pay the required $250.00 monthly surcharge premium.] The Spousal Special Enrollment will only be provided upon request if you wish to enroll your spouse. *If you elect to enroll your spouse for coverage, please refer to last page on '***ways to pay your spousal payments'***.

4. Provide your dependent child(ren) identification information (name, social security number, relationship to you, date of birth and address). **ANSWER ALL QUESTIONS**

5. Complete the Beneficiary Information (*primary* and *secondary* beneficiaries, relationship to you, address, and date of birth). Your beneficiary is the person/persons who will be entitled to receive the Welfare Fund's life insurance benefits upon your death.

6. **SIGN** and **DATE** the Enrollment form
   [The form will be returned to you without a signature or date and can delay the process)

The following documents are required:

Members:

- A copy of your **birth certificate***

Spouses:

- If you **elect to enroll your spouse and pay the Spousal monthly premium**, a copy of your spouse's **birth certificate*** and a **marriage LICENSE*** [*Your marriage license is the document issued by your town's vital statistics office by the town of your marriage*]. ***Church issued certificates are not accepted.***
  For same-sex marriages provide a copy of your **Marriage Certificate**, if you live in a state that authorizes same-sex marriages or a **Civil Union Certificate**, if you live in a state that authorizes civil unions or a **Declaration of Domestic Partnership** and

other required documents, if you live in a state that does not authorize either civil unions or same-sex marriages.

Dependent child(ren):

- Valid **birth certificate(s)*** for your dependent(s) must include the Participants name **(only Long Forms are accepted)**
- Adoption papers for an adopted child(ren)

NOTE:

- ***Long Form Birth certificates for dependent child(ren) are required.***
- ***Dependents must be added within 31 days of birth or adoption. Failure to enroll a new Dependent within 31 days of birth, or adoption or marriage the eligibility will be deferred to the date the documentation is received.***
- ***If the birth certificate is not in English, you must provide a notarized translation.***
- ***Birth certificates issued prior to July 1, 2010 in Puerto Rico, are invalid and can no longer be used to determine eligibility.***
- ***If the marriage license is not in English, you must provide a notarized translation.***
- ***Send only copies of all required documents, the copies are stored in the Fund Office - DO NOT SEND ORIGINALS!!***

Other Insurance information:

- If you have other insurance attach a copy of your Medical ID card (*front and backside of your card*)
- If your dependent child(ren) has other insurance attach a copy of that carrier's medical ID card (*front and backside of their card*)
- If your spouse has other **employer sponsored health insurance**, ***they will not be eligible under the Funds plan***.

1199 New England Health Care Employees
WELFARE & PENSION FUND

77 Huyshope Avenue, 2nd Floor, Hartford, Connecticut 06106-7001

Phone: 1-800-227-4744 or Fax: 1-860-947-8080

ENROLLMENT FORM

PLANILLA DE INSCRIPCION

YOU MUST ANSWER ALL QUESTIONS AND PRINT CLEARLY IN INK

(THIS FORM IS STRICTLY CONFIDENTIAL)

DEBE CONTESTAR LAS PREGUNTAS CLARAMENTE EN TINTA Y CON LETRA DE MOLDE

(ESTA PLANILLA ES ESTRICTUMENTE CONFIDENCIAL)

PLEASE CHECK APPROPRIATE BOX: □ **New Enrollment** □ **Address Change Only** □ **Add/Remove Spouse or Child** □ **Change Beneficiary**

1- PARTICIPANT INFORMATION *La informacion de identificacion personal*

Participant Name (Last, First, Middle Initial) *Nombre del Miembro*			Social Security *de Seguro Social*	
Current Street Address *Domicilio*		City *Ciudad*	State *Estado*	Zip *Zona Postal*
Home Telephone *Area y No. de telefono* ( )	Date of Birth Fecha de Nacimiento	Sex *Sexo*	Marital Status *Estado Civi* Single □ Married □ Separated □ Divorced □	

2- EMPLOYMENT INFORMATION *Escriba la informacion de su empleo*

Name of Employer *Lugar de trabajo actual*			Work Telephone *Trabajo Telefono* ( )
Employer Street Address *Direccion*	City *Ciudad*	State *Estado*	Zip *Zona Postal*
Date of Hire: *Fecha de Empleo* Full Time □ *Tiempo Completo* Part Time □ *Tiempo Parcial*	Hours Per Week on hire date: *Horas por semana dia de contrato* Hourly Rate: $ *Porcentaje por hora*	Job Classification: *Tipo de Trabajo* Department: *Depto*	

Do you currently work a second job with a different 1199 Employer? Yes *Si* □ No *No* □
If "Yes" complete the following information for your second 1199 job
Si tiene un Segundo trabajo con la 1199 nombre el otro lugar donde trabaja

Name of Second Current 1199 Employer *Lugar de trabajo actual*			Work Telephone *Trabajo Telefono* ( )
Employer Street Address *Direccion*	City *Ciudad*	State *Estado*	Zip *Zona Postal*
Date of Hire: *Fecha de Empleo* Full Time □ *Tiempo Completo* Part Time □ *Tiempo Parcial*	Hours Per Week: *Horas por semana dia de contrato* Hourly Rate: $ *Porcentaje por hora*	Job Classification: *Tipo de Trabajo* Department: *Depto*	

Previous Employment in the Health Care Field. Please list the last two (2) previous jobs held in the Health Care Field
Previos Empleos en el Campo de Cuidados de Salud

1. Name of Previous Health Care Employer *Employer Patrono*			Was this job with an 1199 Employer *Posicion de 1199* Yes *Si* □ No *No* □
City *Ciudad*	State *Estado*	Date Employment Began *Fecha del Empleo*	Date Employment Ended *Fecha de Alta*
2. Name of Previous Health Care Employer *Employer Patrono*			Was this job with an 1199 Employer *Posicion de 1199* Yes *Si* □ No *No* □
City *Ciudad*	State *Estado*	Date Employment Began *Fecha del Empleo*	Date Employment Ended *Fecha de Alta*

3- ADD SPOUSE *Attach a copy of marriage license* (*cetificado de matrimonio*) *and birth certificate* (*certificado de nacimiento*).

Name of Spouse (Last, First, Middle Initial) *Nombre v apelido del esposala*	Marriage Date *Fecha de Nacimiento*	Spouse Date of Birth *Fecha de Nacimiento del esposola*	Spouse Social Security *No.del seguro social del esposola*

Does your spouse have other health care insurance? Yes *Si* □ (attach back and front copy of card) No *No* □
Tienen su esposala ylo hijos Seguro de Salud u otra poliza de Segura?

If "Yes" name of health insurance company or plan: _____ Policy/Group #: _____
Nombre de la companla de Seguro/Plan *No. de la poliza*

DELETE SPOUSE ***Attach a copy of Divorce Decree or Separation Agreement***

Name of Spouse (Last, First, Middle Initial) *Nombre v apelido del esposala*	Divorce/Separation Date	Spouse Date of Birth *Fecha de Nacimiento del esposola*	Spouse Social Security *No.del seguro social del esposola*

4- DEPENDENT CHILD INFORMATION* ***Informacion Familiar.*** **If you qualify for dependent coverage from the Fund, your dependent children, to age 26, are eligible for dependent coverage provided that your child is not eligible for other employer sponsored group health insurance through their own employment or their spouse's employment. To enroll Dependent Children a copy of each child's Birth Certificate or Adoption Documentation) is required.** ***(Certificado de Nacimiento(s)/documentacion de adopcion.*** **Physically and/or developmentally disabled children, age 26 or older, may be eligible for additional coverage. Call the Fund Office for information.**

1. Child's Name (Last, First, Middle Initial) *Nombre*	Social Security # *No de Seguro Social*	Son/Daughter *Parentesco*	D.O.B. *Fecha de nocimiento*
Street Address *Domicilio*	City *Ciudad*	State Estado	Zip *Zona Postal*

Is this child age 19-26? Yes *Si* □ No *No*□ If "Yes", Is this child employed? Yes *Si* □ No *No*□

If "Yes *Si*", Name of Employer *Nombre del Patrono*: _____ Full Time *Tiempo Completo* □ Part Time *Tiempo Parcial* □

Employer Address *Direccion*: _____ Telephone Number *No. de telefono*: (____)_____

Is this child eligible for employer sponsored group health coverage through their employment? Yes *Si* □ No *No*□
Is this child eligible for employer sponsored group health coverage through their spouse's employment? Yes *Si* □ No *No*□

If "Yes *Si*", Name and Address of Employer *Nombre del Patrono Direccion*: _____

2. Child's Name (Last, First, Middle Initial) *Nombre*	Social Security # *No de Seguro Social*	Son/Daughter *Parentesco*	D.O.B. *Fecha de nocimiento*
Street Address *Domicilio*	City *Ciudad*	State Estado	Zip *Zona Postal*

Is this child age 19-26? Yes *Si* □ No *No*□ If "Yes", Is this child employed? Yes *Si* □ No *No*□

If "Yes *Si*", Name of Employer *Nombre del Patrono*: _____ Full Time *Tiempo Completo* □ Part Time *Tiempo Parcial* □

Employer Address *Direccion*: _____ Telephone Number *No. de telefono*: (____)_____

Is this child eligible for employer sponsored group health coverage through their employment? Yes *Si* □ No *No*□
Is this child eligible for employer sponsored group health coverage through their spouse's employment? Yes *Si* □ No *No*□

If "Yes *Si*", Name and Address of Employer *Nombre del Patrono Direccion*: _____

If require space to add more dependents please contact the Fund office for an "Additional Dependent" form.

3. Child's Name (Last, First, Middle Initial) *Nombre*	Social Security # *No de Seguro Social*	Son/Daughter *Parentesco*	D.O.B. *Fecha de nocimiento*
Street Address *Domicilio*	City *Ciudad*	State Estado	Zip *Zona Postal*

Is this child age 19-26? Yes *Si* □ No *No*□ If "Yes", Is this child employed? Yes *Si* □ No *No*□

If "Yes *Si*", Name of Employer *Nombre del Patrono*: _____ Full Time *Tiempo Completo* □ Part Time *Tiempo Parcial* □

Employer Address *Direccion*: _____ Telephone Number *No. de telefono*: (____)_____

Is this child eligible for employer sponsored group health coverage through their employment? Yes *Si* □ No *No*□
Is this child eligible for employer sponsored group health coverage through their spouse's employment? Yes *Si* □ No *No*□

If "Yes *Si*", Name and Address of Employer *Nombre del Patrono Direccion*: _____

4. Child's Name (Last, First, Middle Initial) *Nombre*	Social Security # *No de Seguro Social*	Son/Daughter *Parentesco*	D.O.B. *Fecha de nocimiento*
Street Address *Domicilio*	City *Ciudad*	State Estado	Zip *Zona Postal*

Is this child age 19-26? Yes *Si* □ No *No*□ If "Yes", Is this child employed? Yes *Si* □ No *No*□

If "Yes *Si*", Name of Employer *Nombre del Patrono*: _____ Full Time *Tiempo Completo* □ Part Time *Tiempo Parcial* □

Employer Address *Direccion*: _____ Telephone Number *No. de telefono*: (____)_____

Is this child eligible for employer sponsored group health coverage through their employment? Yes *Si* □ No *No*□
Is this child eligible for employer sponsored group health coverage through their spouse's employment? Yes *Si* □ No *No*□

If "Yes *Si*", Name and Address of Employer *Nombre del Patrono Direccion*: _____

FOR MEMBERS ELIGIBLE UNDER THE WELFARE FUND

5- BENEFICIARY INFORMATION- DEATH BENEFIT ***Beneficio de Defuncion.*** **List name and address of person(s) to whom your Death Benefit is to be paid. State how the person(s) are related to you (You cannot name yourself as a beneficiary). If a minor, state age, and give name of parents or guardian in "Remarks". If more than one person is to share the Death Benefit, indicate the percentage or share each is to receive in "Remarks".** Indique nombre y direccion de la persona(s) que debe recibir el Beneficio de Defuncion. Indique el parentesco con la person(s). Si la persona es menor de edad senale la edad y el nombre de los padres o de la personal reponisable del menor en "Notas". Si mas de una persona va a compartir el Beneficio de Defuncion indique en "Notas" el percentage or parte que cada una debe recibir.

Effective Date of Change in Beneficiary		
PRIMARY Beneficiary Name (Last, First, Middle Initial) *Nombre del Beneficiario Primario*	Relationship to You *Parentesco con el Miembro*	Birth Date *Fecha de nacimiento*
Street Address *Domicilio del Beneficiario(ios) Primario*	City *Ciudad* State *Estado*	Zip *Zona Postal*

If the PRIMARY beneficiary is deceased at the time of your death, list the name and address of the SECONDARY person(s) to whom your Death Benefit is to be paid. State how the person(s) are related to you (You cannot name yourself as a beneficiary). If a minor, state age, and give name of parents or guardian(s) in "Remarks". If more than one person is to share the Death Benefit, indicate the percentage or share each is to receive in "Remarks". ***Si el beneficiario primario ha fallecido al tiempo de su muerte, indique nombre y direccion de la persona(s) que debe recibir el Beneficio de Defuncion. Indique el parentesco con la person(s). Si la persona es menor de edad senale la edad y el nombre de los padres o de la persona responsable del menor en "Notas". Si mas de una persona va a compartir el Beneficio de Defuncion indique en "Notas" el percentage or parte que cada una debe recibir.***

SECONDARY Beneficiary Name (Last, First, Middle Initial) *Nombre del Beneficiario Secundario*	Relationship to You *Parentesco con el Miembro*	Birth Date *Fecha de nacimiento*
Street Address *Domicilio del Beneficiario(ios) Primario*	City *Ciudad* *Estado* State	Zip *Zona Postal*
REMARKS: (Other Beneficiary) *Notas:*		

THIS INFORMATION MAY BE USED FOR PURPOSES OF UPDATING THE FUND'S RECORDS.
Esta informacion podrd usarse con el fin de poner al dia mi expediente personl.

THE FORGOING STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.
La declaracion anterior es totalmente clerta y es hecha en pleno ejercicio de mis facultades fisicas y mentales.

Participant Signature *Firma del Miembro* **X**_____ Date *Fecha* _____

Completing the Coordination of Benefit (COB) form

This form is only required if you plan to **add your dependent(s)** to the plan **or** you are covered under another insurance carrier that is *Primary over the Welfare Funds plan*. Your dependent(s) claims for health care benefits will not be processed without a completed **Coordination of Benefits (COB) form**.

How to complete the COB form

The COB form is listed on the next page

If you answer **Yes**, to (page 1):

- Complete **sections 1 and 2** on page 2 then **sign your name and date form**

If you answer **No**, to (page 1):

- Complete **section 1** on page 2 then **sign your name and date form**

<u>Other Insurance information:</u>

- If you have other insurance attach a copy of your Medical ID card (*front and backside of your card*)
- If your dependent child(ren) has other insurance attach a copy of that carrier's medical ID card (*front and backside of their card*)

New England Health Care Employees
WELFARE FUND
77 Huyshope Avenue 2nd Floor, Hartford, Connecticut 06106-7001
Phone: 1-800-227-4744 Fax: 1-860-947-8080

2021 Coordination of Benefits (COB) Participant Questionnaire

Members Name:
ID#/SSN: **Employer:**
Phone Number: **New Phone Number:**_____

Coordination of Benefits (COB) Participant Questionnaire

It is important that you complete and return this form. COB is a way to coordinate benefit payments when you or your eligible dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Please answer the following question:

- **Are you or any of your dependent children who are currently covered by the Fund's health plan also covered by any other health plan (*State Plans for instance HUSKY does not apply – the Fund is primary over State Funded Plans*)?**

Yes ☐ No ☐

Please follow the instructions below:

If Yes, to the above question:

- For other health insurance plans, please complete sections 1 & 2 sign and date form

If No, to the above question:

- Please complete section 1 and sign and date form.

Please fully complete each required section and sign the form or your form will be returned.

COB information must be submitted to the Fund Office or your dependent(s) claims may be delayed

SECTION 1: TO BE COMPLETED BY ALL 1199 FUND PARTICIPANTS

1199 Fund Participant Name (Last Name, First Name)	Birth Date	Employment Status Active ☐ Retired ☐	Date of Retirement (if applicable)
NEH ID Number or Social Security #		Home/Cell Phone Number	

I certify that the information furnished by me on this form is true and correct at this time, and agree to inform the 1199 Fund of any changes.

▶ 1199 Participant Signature Today's Date

SECTION 2: OTHER HEALTH INSURANCE INFORMATION

Name of Policy Holder (Last Name, First Name)	Birth Date	Sex Male ☐ Female ☐	Social Security #	Relationship to You
Name of Other Health Insurance		Policyholder Identification Number		
Other Health Insurance Address		Other Health Insurance Phone #		

Employment Status Active ☐ Retired ☐	Employer's Name	Date of Retirement (if applicable)

Type of Coverage	Medical □	Drug □	Dental □	Vision □
Effective Date	_____	_____	_____	_____
Cancellation Date	_____	_____	_____	_____

Please list any other dependents covered by this other health insurance.
If there are more than six, please check this box ☐ and list the rest on the back of this form.

1. (Last Name, First Name)	Relationship to You	4. (Last Name, First Name)	Relationship to You
2. (Last Name, First Name)	Relationship to You	5. (Last Name, First Name)	Relationship to You
3. (Last Name, First Name)	Relationship to You	6. (Last Name, First Name)	Relationship to You

Participant Signature	**Today's Date**	**Fax: 860-947-8080** **Mail- NEHC Welfare Fund** **77 Huyshope Ave 2nd Floor** **Hartford, CT 06106**
_____	_____	

HOW YOUR BENEFIT LEVEL CHANGES

If your reported wages change, your benefit level can change.

Each month the Fund looks back at the prior three months to see what wage class you earned.
This "look back" determines the benefit level you will be eligible for in the fifth (next) month.

*If the current month is November, the Fund will look at earnings and hours for August, September, and October (the "look-back period") to determine eligibility for the next month, December:

August	+	September	+	October	= (determines eligibility for)	December

[***LOOK – BACK PERIOD***]

Keeping your current benefit level – If you earn the same or a higher wage class two out of three months in the look-back period, you will keep your benefit level in the fifth month.

Moving to a Higher benefit level – If your reported earnings increase, you may move to a higher wage class. If you earn a higher wage class for *two consecutive months*, you will be eligible on the *fourth month*.

Dropping to a lower benefit level – If your reported earnings are reduced, you may move to a lower wage class. If you have earned a lower wage class for *three consecutive months*, you will drop to a lower benefit level in the *fifth month*.

Reinstatement Rule – If you have been on an unpaid authorized leave with a participating employer and eligibility lapses, when you return to work you will be reinstated with benefits at the benefit level you had when you began the leave. To qualify for reinstatement, you must work enough hours upon your return to require your employer to contribute to the Fund on your behalf.

Dependent coverage – Your initial eligibility for dependent coverage is determined when you first become eligible for benefits and your continued eligibility is based on your average hours worked per week. The same three consecutive month look-back rule that the Fund uses to determine your benefit level is applied to your hours worked to determine your eligibility for dependent coverage. If during the applicable look-back period you average 30 hours or more per week, you are eligible for dependent coverage in the coming month.

YOUR BENEFIT COVERAGE

You Are In:	Because You Earn	Your Benefit Level Is:
Wage Class I	At least the lowest minimum full-time weekly wage stated in the Union contract with your employer	You are eligible for the following benefits: • Comprehensive Health Care • Prescription Drugs • Dental Care • Vision • Life Insurance • Accidental Death & Dismemberment • Short-Term Disability
Wage Class II	At least 60% but less than 105% of the lowest minimum full-time weekly wage stated in the Union contract with your employer	You are eligible for the following benefits: • Comprehensive Health Care • Vision • Life Insurance • Accidental Death & Dismemberment • Short-Term Disability
Wage Class III	Less than 60% of the lowest minimum full-time weekly wage and worked the minimum number of hours stated in the Union contract with your employer	You are eligible for the following benefits: • Inpatient Coverage for Hospitalization • Inpatient or Outpatient Surgery and Related Costs • Emergency Room Treatment Services • Inpatient & Outpatient Behavioral Health Treatment • Vision • Life Insurance • Accidental Death & Dismemberment • Short-Term Disability • Office based physician services

YOUR DEPENDENTS' COVERAGE
(Applies to Wage Class I and II only)

If you average at **LEAST** 30 hours per week	Your dependents are eligible for benefits
If you average **BELOW** 30 hours per week	Your dependents are NOT eligible for benefits

YOUR ELIGIBLE DEPENDENT BENEFIT LEVEL

If you are in Wage Class I **AND** have dependent coverage	Your dependents are eligible for the following benefits: • Comprehensive Health Care • Prescription Drugs • Dental Care • Vision
If you are in Wage Class II **AND** have dependent coverage	Your dependents are eligible for the following benefits: • Comprehensive Health Care • Vision
If you are in Wage Class III	Your dependents are **NOT** eligible for benefits

Ways to pay your Spousal or your COBRA payments:

There are a couple of ways in which you can pay your monthly COBRA payments and Spousal Payments to the New England Health Care Employees Welfare Fund. We accept **personal checks**, **money orders** and **bill payment checks issued directly from your bank**. *The Fund does not accept any cash or credit card payments*. To make sure there is no interruption of your health coverage, your payment should arrive at the Fund Office prior to the 1st day of the month. For example, if you are paying for January coverage, your check should be at the Fund no later than December 31st to ensure that there is no interruption in your health coverage. Please include your ID number with your payment.

1. You can write a personal check or get a money order made payable to the New England Health Care Employees Welfare Fund of (N.E.H.C.E.F.) The address to remit payment is: New England Health Care Employees Welfare Fund, 77 Huyshope Ave., 2nd Floor, Hartford, CT 06106. Please include your Membership ID# on your check or money order.
2. You can contact your bank to set up an automatic (or one-time) bill-payment from your account. If you normally pay your bills using your bank's bill-payment feature, then you can add the New England Health Care Employees Welfare Fund (N.E.H.C.E.F.) as a "new Payee". You have the option to set this up as a one-time payment or schedule monthly reoccurring payments. You would need to set the dollar amount up (either COBRA amount if on COBRA or the spousal monthly payment of $250 if your spouse is eligible for coverage under the plan). If you choose to have automatic/reoccurring payment's you can select the date that you would like your bank to issue the checks and that would also be the date the bank debits the money from your account (please allow 7-10 days for your bank to issue the check and allow for mail handling time).