COBRA REIMBURSEMENT REQUEST FORM

Local Number: __________ Date:_____________

Member's Name		
Home Address		
Home Telephone Number	Cell Number	
Is Other Coverage Available:	❑ Yes	❑ No
Family Coverage		Single Coverage
COBRA Monthly Premium Cost:	$	
CO-Pays	Medical $	Prescriptions $
Dependents	Name	Relationship

REASON FOR REQUESTING COBRA REIMBURSEMENT:

The Robert Lilja Members' Relief Fund will reimburse for COBRA benefits or actual expenses. Therefore, only fill out this form if your monthly medical expenses exceed the amount of your COBRA monthly premium. Please be very specific. This information will remain confidential but is needed to authorize your eligibility for COBRA reimbursement. We need to know if you have any pre-existing health condition, what it is what care you receive for it and all costs involved. Documentation must be provided showing all costs for doctors, hospital, prescriptions, etc. for the past two (2) months. Please use the back of this form to provide the necessary information. The final approval for COBRA payments from the Robert Lilja Members' Relief Fund will be the responsibility of the CWA Fund Director.

Signature of Member Date

Approved: Approved

Local Union Committee District Fund Agent