

**SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST**

720 Market St., Ste. 700
San Francisco, CA 94102
Ph: (415) 263-3670 Fax: (415) 263-3672

**APPLICATION FOR HOUR BANK ADVANCE FOR
NON-COBRA CONTINUATION COVERAGE**

[Please note that if this Application is approved, the Hour Bank Advance will provide eligibility for only one month of non-COBRA continuation coverage under the Plan. A new Application must be submitted for each month of continued coverage.]

Please print or type

Full Name _____

Address _____

SS No. (XXX-XX-####) _____

Phone No.: _____

1. Date Coverage Terminated: _____

2. Work Month: _____ (For this Application, your "Work Month" is the second month preceding the month your Plan coverage terminated. For example, if your coverage terminated effective December 1, 2009, your Work Month is October 2009.)

3. Was your employment terminated (either voluntarily or involuntarily) prior to the last day of the Work Month?

Yes

No

If Yes, Date Employment ended: _____

4. Hours are reported to the Trust based on the payroll periods ending in the Work Month. The following information is necessary to determine whether your loss of

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coverage was solely related to the reduction in the work week from 35 to 28 hours. List the record of hours for each Employer separately. (You may provide copies of your paycheck stubs in lieu of completing the following table.)

List All Payroll Period Ending Dates in the Work Month	Name of Employer	Clock Hours	Dates Employed

I certify that the information provided here is correct and accurate. I understand that if I qualify for the advanced hours, under this section III.E., the Plan will deduct from my hour bank reserves any hours in excess of 120 hours that I earn in the future to repay the advance. I understand further that if I terminate employment without having repaid the advance through future hours, I will be billed for the remaining unpaid balance at the prevailing hourly contribution rate.

Signature

Date

[To qualify for the advance, this application must be submitted to the Plan office by no later than the 20th of the month following the month coverage terminated.]