

**BREWSTER TEACHERS ASSOCIATION WELFARE FUND  
REQUEST FOR COBRA PACKAGE**

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYEE SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

NAME OF DEPENDENT(S): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THE ABOVE NAMED DEPENDENT(S) WILL LOSE ELIGIBILITY  
UNDER THE RULES OF THE BTAWF ON \_\_\_\_\_

DUE TO:

\_\_\_\_ LOSS OF STUDENT STATUS

\_\_\_\_ OVER AGE LIMIT

TO RECEIVE A COBRA PACKET PLEASE RETURN THIS FORM TO:

PREFERRED GROUP PLANS, INC.  
P.O. BOX 15136  
ALBANY, NY 12212-5136  
PHONE 1-800-573-7474 FAX 518-641-0325