NY/NE Regional Work & Family Pendant Initiative

Enrollment Guidelines

All NY/NE CWA / IBEW 2213 Verizon employees are eligible for enrollment including CWA Local's 1395, 1302 and 1400.

- This is a pilot program, eligibility for enrollment ends when allocated funds are depleted. All employees will be eligible on a first come first serve basis. Employees can enroll at any time.

- Download an enrollment application at www.regionalwfrc.com go to NY/NE Regional Work & Family page and scroll to Pendant enrollment application.

- Attach a copy of the signed monitoring agreement (Agreement must indicate the billing party and person covered) to your enrollment application and mail via U.S. Mail to:
  NY/NE Regional Work & Family Committee c/o Fund Administrator
  120 Hicksville Road, Room 200-A
  Massapequa N.Y. 11758

- Pendant must be for one eligible family member as specified in your current collective bargaining agreement(s) (two pendants per employee household)

- Reimbursements will be made quarterly, directly to employee during April , July , October and January on the last Friday of the month.

- Only monthly monitoring service fee is reimbursable up to $40.00 per month.

- Acceptable proof of payments must be submitted in the form of: credit card receipt, cancelled check, auto pay or "ACH" debit receipt.

- Employees are eligible to participate in the DCRF, and Pendant programs.

Contact your Local Union Representative or Fund Administrator with any additional questions.

CWA VERIZON IBEW 2213

PENDANT PROGRAM ENROLLMENT APPLICATION

Employee Last Name	Employee First Name	Employee ID #	NCS Date
		VZ ID #	Job Title

☐ CWA Local # _____	☐ IBEW 2213	☐ Management

Home Address	City State Zip
Home Telephone Area Code Number	Cell Phone Area Code Number

Preferred E-Mail Address *(This is the e-mail address we will use to communicate with you)*

Work Information

Work Address	City State Zip	Work Telephone Area Code Number
Family Member's Name (Print)	Relationship to Employee	Family Member's Age
Family Member's Home Address	City State Zip	

Provider Informatiom

Company / Provider's Name (Print)

Company / Provider's Address	City State Zip	Provider's Telephone Area Code Number
Effective Date of Contract	Contract Term and Fees ☐ Month to Month Contract ☐ Quarterly Contract ☐ Annual Contract	
For Office Use Only	Approval Date:	Approved By:

Method of Payment

☐ Credit Card ☐ Check ☐ Auto Pay

I certify, to the best of my knowledge, the information I have provided on this form is correct.

Employee Signature _____ **Date** _____