

# 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](http://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
<input type="checkbox"/> CWA Local # _____	<input type="checkbox"/> IBEW 2213	<input type="checkbox"/> Management	
Home Address		City	State      Zip
Home Telephone Area Code      Number		Cell Phone Area Code      Number	
Preferred E-Mail Address <i>(This is the e-mail address we will use to communicate with you)</i>			
<b>Work Information</b>			
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	
<b>Provider Information</b>			
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 <input type="checkbox"/> Month to Month Contract <input type="checkbox"/> Quarterly Contract <input type="checkbox"/> Annual Contract		
For Office Use Only	Approval Date:		Approved By:
Method of Payment <input type="checkbox"/> Credit Card <input type="checkbox"/> Check <input type="checkbox"/> Auto Pay			
I certify, to the best of my knowledge, the information I have provided on this form is correct.			
Employee Signature _____			Date _____