

# Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

## Self-Contribution Coverage Extension

- Please complete your portion of this application in its entirety.
- Enclose a check or money order made payable to “Carpenters Trusts of Western Washington.”
- Forward your Self-Contribution Coverage Extension application and your check to Carpenters Trust of Western Washington. These documents must reach the Trust Office before your eligibility terminates.
- The Trust Office will notify you, in writing, of acceptance or denial of your application.

### Personal Information

<b>Name: Last, First, Middle</b>		<b>Member Number:</b>		
<b>Home Address:</b>	<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Telephone Number:</b>	<b>Date of Birth:</b>	<b>Marital Status:</b> <input type="checkbox"/> <b>Single</b> <input type="checkbox"/> <b>Married</b> <input type="checkbox"/> <b>Divorced</b>		
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### Choice of Benefits and Monthly Contribution Amount

Self-Contribution Coverage is available for six months but can be renewed for an additional six months if you continue satisfying the necessary requirements. An extension under Self-Contribution Coverage includes only those benefits you and your dependents were eligible for during the first six months under Self-Contribution Coverage. Time loss benefits are not available for any disability that begins while you are eligible under Self-Contribution Coverage.

- Yes**, I am currently employed with a contributing employer.
- Yes**, I am still unemployed and would like to extend participation under Self-Contribution Coverage for an additional period of time not to exceed six months.
- Yes**, I am still temporarily disabled and would like to extend participation under Self-Contribution Coverage for an additional period of time not to exceed six months. **Important:** If you are retiring or your disability appears to be permanent, you may be eligible for disability retirement. Please contact the Retirement Department at the Trust Office.

**Important:** If you or an eligible dependent are covered by another health plan or Medicare, the benefits of this plan are determined after the benefits of the other plan or Medicare.

- Is any family member covered by another medical, vision or dental plan? Yes/No If yes, please indicate the type of coverage, the name and social security number of the insured and the name and telephone number of the other insurance plan:

Name of Insured: \_\_\_\_\_

(over, please)

Name and Telephone Number of Insurance Company: \_\_\_\_\_

Type of Coverage: \_\_\_\_\_ SSN of Insured: \_\_\_\_\_

- I have read this application and understand my rights to elect continuation coverage. I understand that payment is due upon receipt of the bill but not later than the 25th of the same month and that there is no grace period. I further understand that failure to make the necessary self-contribution payment terminates coverage. I also agree to notify the Trust Office if I or any member of my family become(s) covered under another group health plan or entitled to Medicare after the date of Self-Contribution Coverage election. **Important:** Self-Contribution Coverage is provided subject to your eligibility. The plan reserves the right to terminate your coverage retroactively if the individual is determined to be ineligible for coverage. However, I may elect COBRA when Self-Contribution Coverage terminates. Total coverage under Self-Contribution Coverage and COBRA cannot exceed 18 months, or 36 months in the case of a qualified beneficiary (spouse or dependent child) who has a second qualifying event.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_