

Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

Self-Contribution Coverage Application

- 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 Election Notice (ARRA), this application and your check to your Local Union. Your Local Union will complete its portion of the application and forward all documents to the Trust Office. 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. **Important:** Self-Contribution Coverage is for qualifying participants who are unemployed and on the out-of-work list at their carpenters local, and qualifying participants who are temporarily disabled. If you are retired or are retiring, you must contact Participant Services for other coverage options.

Personal Information

Name: Last, First, Middle		Member Number		
<hr/>				
Home Address:	Street	City	State	Zip
<hr/>				
Telephone Number	Date of Birth	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
() _____				

Choice of Benefits and Monthly Contribution Amount

There are two options to choose from (check one only). If you elect to exclude dental benefits, these benefits cannot be reinstated later. Neither option includes time loss benefits:

- Self-Contribution Coverage With Dental:** \$412.00 per month or \$145.00 with COBRA subsidy
- Self-Contribution Coverage Without Dental:** \$342.00 per month or \$120.00 with COBRA subsidy

Is anyone for whom you are seeking Self-Contribution Coverage covered by another medical, vision or dental plan or entitled to Medicare? 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: _____ SSN of Insured: _____

Name and Telephone Number of Insurance Company: _____

Type of Coverage: _____

Are you (the participant) covered under the above coverage? Yes No If yes, when is the earliest it can be effective? _____

Are you (the participant) entitled to Medicare? Yes No

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.

I have read the Self-Contribution Coverage Election Notice (ARRA), this application and the Self-Contribution Coverage Notice 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: _____

Union Authorization

Complete this portion of the application in its entirety and then forward it, with the participant's Self-Contribution Coverage Election Notice, check or money order, to the Trust Office. These documents and check **must** reach the Trust Office before the participant's eligibility term inates. The Trust Office will notify the participant, in writing, of acceptance or denial of the application.

Participant is (check one only):

- Unemployed.*** If the participant is retiring, please contact the Retirement Department at the Trust Office.
- Temporarily Disabled.*** If the participant appears to be permanently disabled, please contact the Retirement Department at the Trust Office.

Participant resides in the geographic area covered by this plan and is available for work (unless disabled) as described below (check one only):

- Participant is on the "out-of-work" list.
- Participant was dispatched to the job on (date): _____
- Apprentice is on the "out-of-work" list and is in good standing with the JATC.
- Apprentice was dispatched to the job on (date): _____
- Participant is, or will be, on active duty in the uniformed services on (date): _____

I hereby certify that the foregoing statements are true, correct and complete to the best of my knowledge.

Union Representative's Signature: _____

Local Union Number: _____ Date: _____

Telephone Number: () _____