

Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

Self-Contribution Coverage Application A07 Plan

- 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 Application A07 Plan 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.
Important: Self-Contribution Coverage is for qualifying participants who are unemployed and on the out-of-work list at the Pacific Northwest Regional Council of Carpenters, 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		
_____		_____		
Home Address:	Street	City	State	Zip
_____	_____	_____	_____	_____
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) and pay one of the following amounts. If you elect to exclude dental benefits, these benefits cannot be reinstated later. Neither option includes time loss benefits:

- Self-Contribution Coverage With Dental:** \$486.00 per month
- Self-Contribution Coverage Without Dental:** \$409.00 per month

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: Medical Dental RX Vision

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.

(OVER)

Mark the appropriate box:

Unemployed. Are you on the out of work list? ___ Yes ___ No If no, call (866) 649-5463 or call the Pacific Northwest Regional Council of Carpenters at (800) 573-8333. If you are retired, please contact Participant Services at the Trust Office at (800) 552-0635.

Temporarily Disabled.

Back to work.

I have read the Self-Contribution Coverage Application A07 Plan 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: _____