

# Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

## Retiree Health Plan Application

### Qualifications

If you qualify and would like to participate in the Carpenters Health and Security Plan of Western Washington – For Retired Carpenters (the Retiree Health Plan), you must complete this application and return it to the Trust Office as follows:

- Within **60 days** of the later of (1) your retirement effective date; or (2) your loss of eligibility under the Carpenters Health and Security Plan of Western Washington – For Employed Carpenters (the Employee Health Plan). Coverage begins on the later of (1) your retirement effective date; or (2) on the first of the month following loss of eligibility under the Employee Health Plan.
- Within **60 days** of your loss of eligibility under another group health plan, other health insurance coverage or COBRA Continuation Coverage. Coverage under the Retiree Health Plan is effective the first of the month following timely receipt of the completed application. You must have a *Notice To Decline Coverage Agreement* on file at the Trust Office and provide the Trust Office with verification of continuous coverage under the other health care plan.

***If you do not apply within these timelines, you forfeit your right to participate.*** The Trust Office will notify you, in writing of the acceptance or denial of your application.

### Retiree 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>Retirement Effective Date:</b>	
(     ) _____		_____	_____	

### Eligible Dependents To Be Covered

<b>Name: Last, First, Middle</b>		<b>Social Security Number:</b>
_____		_____
<b>Name: Last, First, Middle</b>		<b>Social Security Number:</b>
_____		_____
<b>Name: Last, First, Middle</b>		<b>Social Security Number:</b>
_____		_____

(over, please)

2010 Monthly Contribution Rates (Per Person)						
Career Hours In This Plan	Less than 15,000	15,000-24,999	25,000-34,999	35,000-44,999	45,000-54,999	Greater than 54,999
Retirees not eligible for Medicare	\$600	\$570	\$540	\$510	\$480	\$450
Retirees eligible for Medicare	\$319	\$303	\$287	\$271	\$255	\$239
Retirees covered by Secure-Horizons	\$327	\$310	\$294	\$277	\$261	\$245

According to Trust Office records, you have a total of \_\_\_\_\_ career hours under the Carpenters Health and Security Plan of Western Washington.

### Other Insurance

This plan coordinates benefit payments with group or individual health plans. If you have another group or individual health plan, please help ensure accurate payment by providing the following information. You must also include a copy of the other insurance plan's membership card.

<b>Insured's Name:</b>	<b>Plan ID Number:</b>
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<b>Insurance Company's Name:</b>	
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### Monthly Contribution Payment Designation (check one only)

- Automatic deduction from the Carpenters Retirement Plan of Western Washington
- Please bill me monthly (only option for retired Lathers)

### Election Agreement

I have read this application and the enclosed *Retiree Health Plan Enrollment Letter* and understand my rights to elect coverage under the Retiree Health Plan. I understand if I fail to pay any contribution in a timely fashion, this coverage terminates. I also agree to notify the Trust Office if any of my eligible dependents or I become covered under another group or individual health plan, Medicare, or a Medicare Advantage (MA) Plan or Medicare Supplemental Plan. If I (the retiree) have other group coverage, I agree to notify the Trust Office if that coverage terminates. ***Coverage may be revoked, retroactively, if any facts are misrepresented.***

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