

Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

Retiree Health Plan Application B07 Plan

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

Name: Last, First, Middle		Social Security Number		
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Home Address:	Street	City	State	Zip
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Telephone Number	Date of Birth	Medicare Claim Number (from Medicare card)		
() _____	_____	_____		

List all legal dependents to be covered

Dependents ***must*** be eligible for Medicare to participate in the Retiree Health Plan.

Name: Last, First, Middle	Social Security Number
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(over, please)

Monthly Contribution Rates

The monthly cost per person is listed below. You will be billed for this coverage. Your monthly payment is due by the tenth of the month prior to next month's coverage. Your monthly payment must be made by check, money order or by using "bill pay" services through your bank.

Retiree and dependents eligible for Medicare \$363.00 per person

Election Agreement

I have read this application and the enclosed cover 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 (Medigap). 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: _____