# Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

## Retiree Health Reimbursement Account Application

### Qualifications

The Retiree Health Reimbursement Account is available to you or your dependent in the following two circumstances: (1) If you are eligible for medical benefits from the Carpenters Health and Security Plan – For Retired Carpenters (the Retiree Health Plan); or (2) If you are retired under the Carpenters Retirement Plan of Western Washington and eligible for medical benefits from the Retiree Health Plan but currently eligible for medical benefits from COBRA Continuation Coverage. This account is not available for domestic partner coverage.

If you are eligible for medical benefits in one of these two circumstances and would like to pay a portion of your monthly premium from your Retiree Health Reimbursement Account, please complete this application and return it to the Trust Office. If your application is received by the Trust Office by the 20th of the month, your payment designation will be effective on the 1st of the following month. Your monthly benefit from the Carpenters Retirement Plan of Western Washington or your monthly billing will be adjusted accordingly.

### Retiree or Dependent Information

**Name: Last, First, Middle** **Social Security Number:**

**Home Address:** **Street** **City** **State** **Zip**

**Telephone Number:** **Date of Birth:**

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### Monthly Contribution Payment Designation

You can use your Retiree Health Reimbursement Account to pay a specific amount each month up to your total monthly contribution less $10. The amount selected below will be paid each month until your account balance is $0 unless you submit a new application.

☐ I elect to have $ ______________ paid from my Retiree Health Reimbursement Account each month. This amount will not change even if there is a rate change. I understand the balance of my monthly contribution will be paid by my current contribution method (automatic deduction from my Carpenters Retirement Plan or billing).

☐ I elect to have the maximum amount paid from my Retiree Health Reimbursement Account each month. The maximum amount is my total monthly contribution less $10. This amount will automatically change each year if the monthly contribution rate changes. This amount will also change if I add or remove a dependent from the plan. I understand the balance of my

(over, please)

monthly contribution will be paid by my current contribution method (automatic deduction from my Carpenters Retirement Plan or billing).

## Application Agreement

I have read this application and understand my rights to elect payment from my Retiree Health Reimbursement Account.

Signature: ________________________________________ Date: _________________________