

# Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

## Self-Contribution Coverage Application Eastern Washington, Idaho, Montana, Wyoming

- Please complete this application in its entirety.
- Enclose a check or money order made payable to “Carpenters Trusts of Western Washington.”
- Forward your application and check to Carpenters Trusts of Western Washington. Your application and check must reach the Trust Office before your eligibility terminates.
- The Trust Office will notify you, in writing, of the 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 at the Trust Office for other coverage options.

### Personal Information

Name: Last, First, Middle		Member Number		
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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		
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### Choice of Benefits and Monthly Contribution Amount

There are two benefit and payment 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:*** \$540.00 per month
- Self-Contribution Coverage Without Dental:*** \$473.00 per month

### Reason For Applying

Please check the appropriate box below:

- Unemployed.*** Are you on the out-of-work list at the Regional Council?  Yes  No. If no and you want to be, please call the Regional Council dispatch at (866) 649-5463. If you are retired, please contact Participant Services at the Trust Office at (800) 552-0635.
- Temporarily Disabled***
- Back to work***

(over, please)

## Other Insurance

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 (check all that apply):  Medical  Dental  Prescription  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.

## Disclosure and Signature

I read the Self-Contribution Coverage 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: \_\_\_\_\_