Kaiser Permanente

PO Box 1929 Seattle, WA 98111-1929

Self-Contribution Coverage Application
Oregon and SW Washington

Self-Contribution Coverage is for qualifying participants who are unemployed and on the out-of-work list at the Southwest Mountain States Regional Council of Carpenters or the regional council in the jurisdiction in which the participant is working, and qualifying participants who are disabled. If you are retired or are retiring, you must contact Participant Services at Northwest Carpenters Trusts for other coverage options: (800) 552-0635.

- Please complete this application in its entirety.
- Enclose a check or money order made payable to "Northwest Carpenters Trusts."
- Forward your application and check to Northwest Carpenters Trusts. Your application and check must reach Northwest Carpenters Trusts before your dollar bank eligibility terminates.
- Northwest Carpenters Trusts will notify you, in writing, of the acceptance or denial of your application.

Personal Information

Name: Last, First, Middle | Social Security Number

____

Mailing Address: Street | City | State | Zip

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Telephone: ☐ Mobile ☐ Land | Date of Birth | Marital Status: ☐ Single ☐ Married ☐ Divorced

( ) ____

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:

☐ **Medical Benefits:** $665/month

☐ **Medical and Dental Benefits:** $712/month

Reason For Applying

Please check the appropriate box below:

☐ **Unemployed.** You must be on the out-of-work list at the Southwest Mountain States Regional Council of Carpenters or the regional council in the jurisdiction in which you are working. Are you on the out-of-work list? ☐ Yes ☐ No. The Regional Council dispatch telephone number is: (866) 649-5463.

☐ **Disabled**

☐ **Back to work with (name of employer)** _______________________
Employer's telephone number _______________________

(over, please)

Disclosure and Signature

I read the *Self-Contribution Coverage Application* and the *Self-Contribution Coverage Election 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 Northwest Carpenters Trusts 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: ______________________