Northwest Carpenters Health and Security Plan

PO Box 1929 Seattle, WA 98111-1929

Retiree Coverage Application

Washington

Qualifications and Deadlines

If you qualify for and would like to participate in Retiree Coverage as described in the *General Notice of Retiree Coverage Rights*, you must complete this application and return it to Northwest Carpenters Trusts within 60 days of the later of:

- Your retirement date under the Northwest Carpenters Retirement Plan;
- Your loss of dollar bank eligibility or COBRA; or
- Your loss of eligibility under another group health plan or other health insurance coverage. You must provide Northwest Carpenters Trusts 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. We will notify you in writing of the acceptance or denial of your application and your monthly rate.

Retiree Information

Name: Last, First, Middle			Social Security Number	
Mailing Address:	Street	City	State	Zip
Telephone Number ☐ Mobile ☐ Land		Date of Birth	Retirement Date	
( )				

List Each Person You Want Covered (Including the Retiree)

You **must** list each person who should be covered under Retiree Coverage **including yourself.** If, for example, only your spouse should be covered, please provide his or her name in the appropriate (second) space below and leave the space for you (the retiree) blank.

Retiree's Name: Last, First, Middle	Social Security Number	Eligible For Medicare?
		☐ Yes ☐ No
Spouse's Name: Last, First, Middle	Social Security Number	Eligible For Medicare?
		☐ Yes ☐ No
Child's Name: Last, First, Middle	Social Security Number	Eligible For Medicare?
		☐ Yes ☐ No
Child's Name: Last, First, Middle	Social Security Number	Eligible For Medicare?
		☐ Yes ☐ No

If you or a dependent is eligible for Medicare, you **must** submit a copy of the Medicare card(s).

(over, please)

What You Pay

Your monthly contribution rate is based on the following three factors. Please include a check with this application. If you need assistance determining your monthly rate, please contact Participant Services at Northwest Carpenters Trusts: (800) 552-0635.

- The number of people covered under the plan. Your monthly rate will not exceed the rate for two people even if you have more than one dependent, except for the dental and vision option. Please see the 2024 rates below.
- Your service-based subsidy based on the number of hours reported to the Northwest Carpenters Health and Security Plan during your career. Your career hours equals: _____
- If you and/or your dependents are eligible for Medicare.

2024 Monthly Contribution Rates						
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	$1,231/person	$1,170/person	$1,108/person	$1,047/person	$985/person	$923/person
Retirees eligible for Medicare	$577/person	$548/person	$519/person	$490/person	$461/person	$432/person

Monthly Contribution Payment Designation (check one only)

☐ Automatic deduction from the Northwest Carpenters Retirement Plan
☐ Bill me monthly

Life Insurance Beneficiary

The Northwest Carpenters Health and Security Plan includes a life insurance benefit for you and your dependents. List the person who should receive your life insurance benefit if you die. Subject to the applicable community property laws, your life insurance beneficiary can be anyone except an employer and yourself.

Name: Last, First, Middle	SSN	Date of Birth	Relationship

Election Agreement

I have read this application and the *General Notice of Retiree Coverage Rights* and understand my rights to elect Retiree Coverage under the Northwest Carpenters Health and Security Plan. I understand if I fail to pay any contribution in a timely fashion, this coverage terminates. I also agree to notify Northwest Carpenters Trusts if I or any of my eligible dependents 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 Northwest Carpenters Trusts if that coverage terminates. Coverage may be revoked, retroactively, if any facts are misrepresented.

Signature: _____ Date: _____