

Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

Self-Contribution Extension

- Please complete your portion of this application in its entirety.
- Enclose a check or money order made payable to "Carpenters Trusts of Western Washington."
- Forward this application and your check to your Local Union. Your Local Union will complete its portion of the application and forward it to the Trust Office. Your application must reach the Trust Office before your eligibility terminates.
- The Trust Office will notify you, in writing, of acceptance or denial of your application.

Personal Information

Date of Notice

Name: Last, First, Middle		Member Number:		
Home Address:	Street	City	State	Zip
Telephone Number: ()	Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		

Choice of Benefits and Monthly Contribution Amount

Self-Contribution Coverage is available for a six-month period but can be renewed for an additional six months if you continue satisfying the necessary requirements. An extension under Self-Contribution Coverage includes only those benefits you and your dependents were eligible for during the first six months under Self-Contribution Coverage. Time loss benefits are not available for any disability that begins while you are eligible under Self-Contribution Coverage.

- Yes**, I am currently employed with a contributing employer.
- Yes**, I am still unemployed and would like to extend participation under Self-Contribution Coverage for an additional period of time not to exceed six months.
- Yes**, I am still temporarily disabled and would like to extend participation under Self-Contribution Coverage for an additional period of time not to exceed six months. **Important:** If you are retiring or your disability appears to be permanent, you may be eligible for disability retirement. Please contact the Retirement Department at the Trust Office.

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.

- Is any family member covered by another medical, vision or dental plan? 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: _____

Name and Telephone Number of Insurance Company: _____

(over, please)

Type of Coverage: _____ SSN of Insured: _____

- I have read this application 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: _____

Union Authorization

Complete this portion of the application in its entirety and then forward it, with the participant's check or money order, to the Trust Office. This application and check **must** reach the Trust Office before the participant's eligibility terminates. The Trust Office will notify the participant, in writing, of acceptance or denial of the application.

Participant is (check one only):

- Unemployed.*** If the participant is retiring, please contact the Retirement Department at the Trust Office.
- Temporarily Disabled.*** If the participant appears to be permanently disabled, please contact the Retirement Department at the Trust Office.

Participant is in the Western Washington area and is available for work (unless disabled):

- Participant is on the "out-of-work" list.
- Participant was dispatched to the job on (date): _____
- Apprentice is on the "out-of-work" list and is in good standing with the JATC.
- Apprentice was dispatched to the job on (date): _____
- Participant is, or will be, on active duty in the uniformed services on (date): _____

I hereby certify that the foregoing statements are true, correct and complete to the best of my knowledge.

Union Representative's Signature: _____

Local Union Number: _____ Date: _____

Telephone Number: () _____