Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

Self-Contribution Coverage Extension

- 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 Trust of Western Washington. Your application and check must reach Carpenters Trusts before your eligibility terminates.
- Carpenters Trusts will notify you, in writing, of acceptance or denial of your application.

Personal Information

Name: Last, First, Middle Social Security Number

_____

Mailing Address: Street City State Zip

_____

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

( ) _____

Reason For Applying

Self-Contribution Coverage is available for six months 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 the following contributing employer:

Name of employer: _____ Telephone number: ( ) _____

☐ ***Yes,*** I am still unemployed and on the out-of-work list at the Pacific Northwest Regional Council of Carpenters or the regional council in the jurisdiction in which your are working 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. I am including my *Self-Contribution Coverage Certificate of Disability* with this application. **Important:** If you are retiring or your disability appears to be permanent, you may be eligible for disability retirement. Please contact Retirement Services at Carpenters Trusts: (800) 552-0635.

Other Insurance

Is anyone for whom you are providing 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:

(over, please)

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 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 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: _____