Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

Self-Contribution Coverage Application
Western and Central Washington

- 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 Carpenters Trusts before your eligibility terminates.
- Carpenters Trusts 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 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 Carpenters Trusts for other coverage options.

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

( ) _____

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:** $555/month

☐ **Medical and Dental Benefits:** $612/month

Reason For Applying

Please check the appropriate box below:

☐ **Unemployed.** You must be on the out-of-work list at the Pacific Northwest 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. If you are retired, please contact Participant Services at Carpenters Trusts: (800) 552-0635.

☐ **Disabled**

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

(over, please)

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:

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 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 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: _____