Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

Retiree Coverage Application

Western and Central 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 Carpenters Trusts within 60 days of the later of:

- Your retirement date under the Carpenters Retirement Plan of Western Washington;
- 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 have a *Notice To Decline Coverage Agreement* on file at Carpenters Trusts and provide 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. Carpenters Trusts 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 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. Please see the 2017 rates below.
- Your service-based subsidy based on the number of hours reported to the Carpenters Health and Security Plan of Western Washington during your career. Your career hours equals: _____
- If you and/or your dependents are eligible for Medicare.

2017 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	$883/person	$839/person	$795/person	$751/person	$706/person	$662/person
Retirees eligible for Medicare	$484/person	$460/person	$436/person	$411/person	$387/person	$363/person

If you qualify and would like to apply for SecureHorizons, please contact Retirement Services at Carpenters Trusts for a special application.

Other Insurance

Do you or any dependent applying for Retiree Coverage have other group or individual insurance?
☐ Yes ☐ No. If yes, please complete the enclosed *Other Insurance Inquiry*.

Monthly Contribution Payment Designation (check one only)

☐ Automatic deduction from the Carpenters Retirement Plan of Western Washington
☐ Bill me monthly

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 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 Carpenters Trusts if any of my eligible dependents or I 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 Carpenters Trusts if that coverage terminates. Coverage may be revoked, retroactively, if any facts are misrepresented.

Signature: _____ Date: _____