Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

Retiree Coverage Application

Eastern Washington, Idaho, Montana, Wyoming

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 Washington, Idaho, Montana, Carpenters-Employers Retirement Plan;
- Your loss of dollar bank eligibility, including COBRA; or
- Your loss of eligibility under another group health plan or other health insurance coverage. You must 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**

Home 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** identify 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 two 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 2018 rates below.
- If you and/or your dependents are eligible for Medicare.

Who Is Covered	**Monthly Rate**
Retiree and/or dependents not eligible for Medicare	$971/person
Retiree and/or dependents eligible for Medicare	$460/person

After you make your first payment, you will be billed for this coverage. Your monthly payment is due by the tenth of the month prior to next month's coverage. Your monthly payment must be made by check, money order or by using "bill pay" services through your bank.

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.*

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 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 Carpenters Trusts if that coverage terminates. Coverage may be revoked, retroactively, if any facts are misrepresented.

Signature: _____ Date: _____