Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

Notice to Decline Coverage Agreement

(Reserving Your Rights to the Retiree Health Plan)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), allows certain individuals a special opportunity to enroll in the Carpenters Health and Security Plan of Western Washington – For Retired Carpenters (the Retiree Health Plan) if enrollment was initially declined. Special enrollment rights apply as described below.

Loss of Other Health Care Coverage

You (the retiree) or your dependents who are otherwise eligible for coverage but not enrolled may enroll for coverage if all of the following requirements are met:

- Enrollment in the Retiree Health Plan was declined because you or your dependents were covered under another group health plan or other health insurance coverage when initially eligible to enroll in the Retiree Health Plan.
- The other health care coverage terminated due to (1) loss of eligibility including loss due to legal separation, divorce, death, termination of employment or reduction in work hours; (2) termination of employer contributions; or (3) if the other coverage was under a COBRA Continuation Coverage provision, the maximum coverage period was exhausted. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan.
- When enrollment was declined, a *Notice to Decline Coverage Agreement* was completed which reserved enrollment rights for you or your dependents in the Retiree Health Plan after loss of eligibility under the other group health plan or the other health insurance coverage.

To enroll, you must complete and submit to the Trust Office a *Retiree Health Plan Application* for you and your dependents no later than 60 days after your or your dependents' other health care coverage terminates. A certificate of prior coverage and a copy of the other plan's termination of coverage notice must be provided to the Trust Office with the application.

Coverage under the Retiree Health Plan is effective the first of the month following timely receipt of the completed application. If the completed application is not received within 60 days, the right to enroll is forfeited.

(over, please)

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Retiree Information: Date:

Name: Last, First, Middle			Member Number:	
Home Address:	Street	City	State	Zip
Telephone Number: ( )		Date of Birth:	☐ Single ☐ Married ☐ Divorced	

Notice To Decline Coverage Agreement

I, the undersigned retiree and/or spouse, have read this agreement and understand that I have been offered and am declining coverage under the Carpenters Health and Security Plan – For Retired Carpenters at this time. It is understood and agreed that, by the execution of this *Notice To Decline Coverage Agreement,* I am reserving my right to enroll in the Carpenters Health and Security Plan – For Retired Carpenters, but only if I later qualify for special enrollment as described in this notice. I am declining coverage for the following reason (please check *Option 1* ***or*** *Option 2* only):

Option 1

☐ I and/or my spouse are currently covered under another group health plan or other health insurance coverage. Please provide the information requested below. You must also include a copy of the other insurance plan's membership card.

Insured's Name:	Plan ID Number:
Employer's Name:	Insurance Company's Name:
Dependent's Covered:	Dependent's Covered:
Type of Coverage: ☐ Group ☐ Individual ☐ COBRA	
Who Is Covered (check all that apply)?: ☐ Retiree ☐ Spouse ☐ Children	

Option 2

☐ I do not want to participate in the Carpenters Health and Security Plan – For Retired Carpenters. I understand that I *permanently* forfeit my rights to this plan.

Retiree's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____