

U.A. LOCAL 159 HEALTH & WELFARE TRUST

4160 Dublin Blvd., Suite 400, Dublin, CA 94568
Telephone: (866) 295-6402
Fax: (925) 833-7301

APPLICATION FOR UA LOCAL 159 RETIREE HEALTH & WELFARE COVERAGE

Trust Fund records show you are eligible to continue participation in the Health and Welfare Plan as a retiree. In order to determine Health and Welfare rates for you and your eligible dependents, you must submit proof if you are Medicare eligible. This application must be completed and returned to the Trust Fund Office within 30 days or within 30 days prior to the termination of your coverage under the Active Plan.

Please print your Name and SS#: _____

Print Dependent Spouse's Name: _____

Print Dependent Children's Names and Birthdates: _____

YOU, YOUR SPOUSE AND CHILDREN CAN BE COVERED ONLY AT THE FOLLOWING TIMES:

1. Immediately upon retirement (and after Active coverage ends).
2. Within 30 days of loss of prior coverage under other group insurance. You must provide proof of loss of this prior coverage for yourself and the dependents you wish to enroll. If you delay enrolling because of other group coverage, you cannot apply to make self-payments until coverage under your other plan ends.
3. At the time you become Medicare eligible.

Please refer to the Plan's rules for a complete description of the eligibility requirements for Retiree Health and Welfare coverage. Retirees are eligible for the medical, prescription, hearing aid and vision benefits of the Plan only.

☐ **I hereby apply for Retiree Health and Welfare coverage (to commence after my coverage under the Active Plan has terminated) for myself and my eligible dependents, listed above. I have read and understand the eligibility restrictions for coverage of dependents.**

OR

☐ **I wish to delay applying for Retiree Health and Welfare coverage until:**

_____ a. I become eligible for Medicare _____ b. My other group insurance terminates
(Submit proof of other insurance)

OR

☐ **I DO NOT WISH TO CONTINUE PARTICIPATION IN THE RETIREE HEALTH AND WELFARE PLAN.**

(Please complete reverse side)

*******DEDUCTION AUTHORIZATION*******

I hereby authorize the Fund Manager to deduct an amount from my monthly pension benefit to pay for my Retiree Health and Welfare coverage. This deduction is for the purpose of paying, in advance, the contributions required for continued coverage for myself and my eligible dependents under the U.A. Local 159 Health and Welfare Plan. The Fund Manager is authorized to make a monthly deduction in the following amount:

Medicare Eligible Retirees

The Retiree must submit a copy of his/her Medicare card to qualify.

- ☐ **\$165.00** I am enrolled in the Medicare-risk program of the Kaiser Health Plan.
- ☐ **\$220.00** I am enrolled in the Medicare-risk program of the United Health Care (AARP) HMO Plan.

Non-Medicare Eligible Retirees

- ☐ **\$430.00** Retiree who retired on or after age 60.
- ☐ **\$515.00** Retiree who retired on or after age 55 and before age 60
(Rate applies from date of retirement until the retiree has been covered for as many months after attainment of age 60 as he or she was covered prior to age 60).
- ☐ **\$715.00** Retiree who retired on or before age 55
(Rate applies from date of retirement until the retiree has been covered for as many months after attainment of age 55 as he or she was covered prior to age 55).

I understand that this is not an assignment of my pension benefits, but is a voluntary authorization to deduct health and welfare premiums from my monthly pension benefit for direct payment to the UA Local 159 Health and Welfare Trust. I also understand that this authorization is revocable by at any time by a written notice delivered to the Fund Manager at HSBA, 4160 Dublin Blvd., Suite 400, Dublin, CA 94568.

(Signature)

(Date)