

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 (Individual Employer Rules)

Trust Fund records show you are eligible to continue participation in the Health and Welfare Plan as an Employer 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 enclosed Plan's rules for a complete description of the eligibility requirements under which an Individual Employer may participate in the Retiree Health and Welfare coverage.

☐ 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 rules as an Employer and the 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, and understand that the amount is subject to periodic review and adjustment based on the actual costs of the Plan.

Non-Medicare Eligible (Owner) Retirees

[] \$1,200 per month.

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)

Retiree Coverage for Individual Employers

1. Eligibility for Individual Employers: An Individual Employer may elect upon retirement to continue coverage for himself or herself and his or her dependents if he or she satisfies all of the following conditions:
 - a) The Individual Employer had been continuously eligible for benefits under the Plan for at least 120 months immediately prior to retirement; and
 - b) The Individual Employer was at least 60 years of age at the time of retirement; and
 - c) The Individual Employer makes timely premium payments in such amounts as are determined from time to time by the Board of Trustees; and
 - d) The Individual Employer and his or her spouse maintain eligibility for Medicare Parts A and B, commencing as soon as each is eligible to do so.
2. A retiree's eligible dependents will be limited to those persons who were eligible dependents on the retiree's date of retirement, or, in the case of a preretirement death, on the date of the employee's death. No dependent acquired after such date shall be covered.
3. Eligibility for Surviving Spouses of Individual Employers: The surviving spouse of an Individual Employer may, upon the death of the Individual Employer, elect to continue coverage for himself or herself and the other then-covered dependents of the Individual Employer, under the conditions stated in subsection (1), if the Individual Employer was either covered, or eligible to elect coverage, as a retired Individual Employer at the time of his or her death.
4. Termination of Retiree Coverage: Coverage will terminate for any person covered under this Section C upon the occurrence of any of the events which would cause termination of coverage of a Retired Employee, except failure to maintain membership in good standing in U.A. Local No. 159.
5. Benefits Provided:

Except as provided in subsection 2, individuals covered under this Section III and their dependents shall be entitled to the same options of HMO, and the same other scheduled benefits, as active employee participants and their dependents, and are subject to the same exclusions and conditions with the exception that the calendar year deductible for the Dental Plan is \$150 per individual and \$450 per family. In addition, Retired Individual Employers shall not be eligible for the Retiree Welfare Stipend.

