Election and Deduction Form for Retiree Coverage

Part I. Retiree/Spouse Information

Retiree Name: _____ Date of Retirement: _____

Retiree SS#: _____ Retiree DOB: _____

Spouse's Name (if applicable): _____ Spouse's SS#: _____

Part II. (To Be Completed by Fund Office) Retiree Age and Years of Service Information

Retiree Age at Date of Retirement: _____ Yrs.

Retiree Years of Service (Full Pension Credits) at Date of Retirement: _____ Pension Credits

Part III. Election for Coverage and Method of Payment

Note: The month you receive your first pension check is the month you begin paying for retiree healthcare coverage.

A. Election for Coverage (Please place an "X" in the appropriate box)

☐ ***I decline to participate in the Sheet Metal Workers' Local 73 Welfare Plan.***

☐ ***I elect to participate in the Sheet Metal Workers' Local 73 Welfare Plan (Choose 1 of the following)***

- ☐ Monthly Premium for Retiree Coverage Only: _____
- ☐ Monthly Premium for Retiree and Spouse Coverage: _____
- ☐ Monthly Premium for Surviving Spouse Coverage: _____
  (Premium Amount based on Surviving Spouse's Age and Retiree's Years of Service)

If coverage includes Non-Medicare Eligible Dependent Child(ren) please "X" below

☐ Additional Premium for Single Coverage for Non-Medicare Eligible Dependent Child(ren) is $_____ per month.

B. Method of Payment (Please place an "X" in the appropriate box)

☐ I elect to have my self-payment for retiree and/or dependent medical benefits deducted from my Local 73 pension check each month or the amount of my Local 73 pension check that is directly deposited into my bank account each month.

☐ I elect to be billed monthly by the Fund Office for retiree and/or dependent medical benefits.

Part IV. Acknowledgement and Signature

I understand that if I decline to enroll at this time in the Sheet Metal Workers' Local 73 Welfare Plan that I *MAY NOT* be eligible to reapply in the future unless I qualify under the Plan's deferment of coverage rules. I also understand that participation in the Welfare Fund's retiree medical benefits is voluntary.

Please sign, date and return this form to the Fund Office as soon as possible.

Retiree Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Note: Welfare coverage for retirees, surviving spouses and dependents is only available for those individuals who meet the Welfare Fund's eligibility rules for coverage. If you are not eligible for retiree medical benefits offered by Sheet Metal Workers' Local 73 Welfare Fund, please disregard this form.