San Francisco Electrical Workers
Retiree Health and Welfare Program

720 Market St., Suite 700 ◆ San Francisco, CA 94102
(415) 263-3670 ◆ Fax (415) 263-3674

{union bug}

Application for Retiree Health and Welfare Coverage

1. Name of Participant ______________________________
   (must be completed in all cases)
   Social Security No. ______________________ Birthdate ______________

2. If Participant is Deceased, NAME OF APPLICANT ______________________

   Social Security No.______________________ Birthdate ______________

3. Address ______________________________

   ____

   Phone No. ______________________ E-Mail ______________

4. I am applying for the following Health & Welfare Benefits: ❑ Normal ❑ Disability ❑ Dependent Only

5. Last Date of Participant's Employment (or last date you intend to work): ______________

6. Retirement Date (if different from above): ______________________

7. Name of Spouse ______________________________

   Social Security No. ______________________ Birthdate ______________

8. Dependent Children <u>Under</u> Age 19:

Name:	Birthdate:

(If additional space is needed to list dependents, please attach a separate page.)

9. Dependent Children Age 19 and over (Full-time Students are eligible until age 23):

Name:	Birthdate:	Full Time Student?	School and No. of Units

(If additional space is needed to list dependents, please attach a separate page.)

10. If applying for Dependent Only Benefits, is proof of Participant's death attached?

    ❑ Yes ❑ No Date of Participant's Death: ______________________

11. If, in the last 15 years, you worked out of other Locals which participated in the Electrical Workers Retiree Health and Welfare Plan, please list the Locals and dates of such employment in the space below:

    ____

    ____

    ____

    ____

12. If you are applying for disability benefits:

Date of Disability: ______________________ Have you been continuously disabled since that date? ❑ Yes ❑ No

Have you applied for a Social Security Disability Award? ❑ Yes ❑ No

<u>If "No", please do so immediately.</u> Application for Social Security Disability Benefits is required for disability benefits eligibility under the plan.

If "Yes", date of application: ________________________________

If "Yes", has award been granted? ❑ Yes ❑ No If "Yes", please attach copy of award. If "No", please explain:

____

____

Have you applied for a waiver of premium for your life insurance benefit? ❑ Yes ❑ No If "No" please do so immediately.

Proof of Birth

This application is accompanied by:

❑ Birth Certificate
❑ Letter from Social Security Administration establishing that you have retired and established your entitlement to Social Security Benefits and *includes birth date used for such entitlement*.
❑ Court Decree establishing fact of birth.
❑ Certification of NEBF eligibility.
❑ Other, please specify ____
Note: Only in the most compelling and unusual circumstances will the Trustees accept any proof of birth other than the first four listed above. The processing of your application will be delayed if satisfactory proof of birth is not submitted with this application.

Declaration of Applicant

I understand that if I engage in employment in any month after my retirement, I must notify the Trustees in writing within fifteen days after my return to employment. Retiree Health and Welfare benefits will be terminated at the end of the third month following the date on which I return to work or if earlier, the date I re-establish my eligibility in the Health and Welfare Plan.

I understand that any clerical or other error made that results in any payment to which I am not entitled under the terms of the plan will be promptly repaid. The Board of Trustees reserves the right to adjust the benefits of the Plan; such adjustment shall not be made on a retroactive basis.

I understand that I, and my dependents must apply for Parts A and B of Medicare as soon as we become eligible. I understand that I, and my dependents will be assumed to have full Medicare coverage (Parts A and B) whether or not enrolled for the full coverage. I further understand the Plan will process any eligible claims incurred on or after that date as though it is supplementary to Medicare coverage, even if I, or my dependents fail to enroll. Members or dependents who are eligible to enroll in Medicare and who have selected one of the Plan's HMO's must enroll in that HMO's Medicare Risk Program, if available and provided they reside in the HMO's Medicare Risk service area. I understand we will be billed the difference between the premium charged to the Plan and the premium for the Medicare Risk Program if either I and/or my dependents fail to enroll in the Medicare Risk Program.

I further understand that no person has the authority to make an oral statement or assurance or promise to vary the terms of the Plan or Trust and I am not relying on any oral or other statement of a person in submitting this application.

In applying for retiree coverage, I certify that all questions have been answered to the best of my ability and all statements are true. I understand the Trustees may deny benefits and recover any benefits paid if any false statements have been made.

Date: ______________________ Signature: ____
Applicant

I understand that benefits will cease in the event of my remarriage and I will notify the Trustees if such event occurs.

Date: ______________________ Signature: ____
Spouse