ALASKA CARPENTERS HEALTH & WELFARE PLAN
RETIREE MEDICAL COVERAGE ENROLLMENT FORM

MEMBER:____ SS#__________________________ WPAS I.D. #______________

☐ **I/we elect Retiree Medical Coverage as follows**: (Check only one selection in either I or II below.)

I. Medical with Prescription Coverage: Member Only

(Note: The Catastrophic Plan is only available to non-Medicare-eligible individuals; once you become eligible for Medicare you will be covered under the Medicare supplemental provisions of the Regular Plan. Proof of Medicare eligibility is required.)

☐ **Catastrophic Plan**

☐ **Regular Plan:** If you are eligible for Medicare check here ☐

II. Medical with Prescription Coverage: Member, Spouse and Dependents listed below

(Note: If the Catastrophic Plan is selected but either the member or spouse is eligible for Medicare, the Medicare-eligible individual will be covered under the Medicare supplemental provisions of the Regular Plan. Proof of Medicare eligibility is required.)

☐ **Catastrophic Plan:** Check if eligible for Medicare: ☐ Member ☐ Spouse
☐ **Regular Plan:** Check if eligible for Medicare: ☐ Member ☐ Spouse

SPOUSE:____ BIRTH DATE:_________________________
DEPENDENT:____ BIRTH DATE:_________________________
DEPENDENT:____ BIRTH DATE:_________________________

☐**IV. VISION COVERAGE:** Check this line to include vision coverage for all covered individuals.

I hereby authorize the Trustees of the Southern Alaska Carpenters Retirement Plan to deduct from my monthly pension check the monthly premium for Retiree Medical Coverage under the Alaska Carpenters Health & Welfare Plan. I realize that the premiums for this Retiree Medical Coverage are set on an annual basis and that I will be notified in advance of any premium changes or other rate adjustments required to continue this coverage.

I retain the right to cancel my Retiree Medical Coverage at any time by written notification to the Plan Administrator of the Alaska Carpenters Health & Welfare Plan. I understand, however, that if I should discontinue this coverage for any reason, I cannot re-enroll in the Retiree Medical Coverage.

I realize that this Retiree Medical Coverage will be terminated on the earlier of either my voluntary cancellation, my failure to pay the monthly premium or my death. I understand, however, that if I choose a Spouse Option and enroll my spouse and/or dependents under the Retiree medical Coverage at this time, their coverage, if still in effect, may continue after my death until they decline coverage or fail to pay the monthly premium. **I am aware that Retiree Medical Coverage is not guaranteed and may be modified or terminated by the Board of Trustees at any time.**

SIGNATURE____ DATE______________________

☐ **I elect to WAIVE Retiree Medical Coverage while other Group Medical Coverage is in effect, proof of my other coverage is attached. I understand I must contact the Administration Office in writing within 30 days of the termination of other coverage and provide proof of termination of other Group coverage in order to re-enroll in this Plan.**

☐ **I elect to WAIVE SPOUSE coverage** while Spouse's other Group Medical Coverage is in effect. Proof of my Spouse's other coverage is attached. I understand I must contact the Administration Office in writing within 60 day's of the termination of my Spouse's coverage and provide proof of termination of Spouse's other Group coverage in order to re-enroll my Spouse in this Plan.

SIGNATURE____ DATE______________________

(12/2007)