OFFICE USE ONLY
DATE PROCESSED: _____
PROCESSOR: _____-

District Council 16 Health and Welfare

Retiree Election Form

☐ **RETIREE** ☐ **SURVIVING SPOUSE**

LAST NAME	FIRST NAME	MI	DATE OF BIRTH / /
ADDRESS & CITY	STATE	ZIP	SEX	SOCIAL SECURITY #: - -
EMAIL ADDRESS	TELEPHONE #: ( )	KIDNEY TRANSPLANT OR/ DIALYSIS ☐ ☐	RECEIVING MEDICARE ☐ PART A ☐ PART B

If you retire from active hourly employment as a Participant in **District Council 16 Northern California Health and Welfare Trust Fund**, you will be eligible for benefits as a Retiree if you meet all of the requirements noted in the District Council 16 Health and Welfare Summary Plan Description book under *Eligibility Rules for Retired Employees – Page 12.*

Reminder: If you choose not to participate in the Retired Employees' benefits Plan immediately upon retirement, you may not enroll at a later date, except as provided in **Retiree Special Late Enrollment Rights.*

I ELECT TO PARTICIPATE IN THE FOLLOWING RETIREE HEALTH PLAN: (Choose one)

- ☐ Direct Pay Plan
- ☐ Kaiser Plan for those not eligible for Medicare
- ☐ Kaiser Senior Advantage Plan for those who are eligible for Medicare

I ELECT TO PARTICIPATE IN THE FOLLOWING RETIREE DENTAL PLAN: (Choose one)

*You may select coverage with the Dental Plan only at the time of your initial enrollment for Retiree Coverage.

- ☐ Delta Dental PPO Plan
- ☐ Delta Care USA Plan
- ☐ United HealthCare/PUD

I ELECT THE FOLLOWING PAYMENT METHOD: (Choose one)

- ☐ I wish to have my monthly contribution deducted from my pension check.
- ☐ I wish to make self-payments for the monthly contribution due. I understand that payment must be made to the Trust Fund Office prior to the month in which payment is due. Failure to make the required self-payments will cause cancellation of the select health plan coverage without the possibility of reinstatement.

DEPENDENT DATA

FULL NAME	RELATION	SEX	DATE OF BIRTH	SOCIAL SECURITY#	RECEIVING MEDICARE PART A OR B	KIDNEY TRANSPLANT OR DIALYSIS
SPOUSE OR DOMESTIC PARTNER:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						

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You Must Enroll in Medicare Part A and Part B: (Check One)

☐ I am eligible for Medicare ☐ I am **not** eligible for Medicare

Retirees are eligible for Medical Plan benefits (including Prescription Drugs, Mental Health/Substance Abuse and Vision Benefits). You also have the option to pay for Dental Benefits. ***Once you or your Spouse or Domestic Partner become eligible for Medicare due to age, disability or renal disease, you MUST enroll in both Parts A and B of Medicare.*** *If you are in the HMO, you must assign those benefits to the HMO.* ***If you are in the Indemnity Medical Plan, medical benefits for you or your Spouse (or Domestic Partner) will be paid as if you are enrolled in Medicare (whether you are or not) and Medicare has paid benefits first.***

THIS FORM MUST BE SIGNED IN ORDER TO PROCESS:

The monthly contribution for my chosen plan(s) is $_____.00

_____
Applicant's Printed Name

_____ _____
Applicants Signature Date:

MUST BE COMPLETED BY LOCAL UNION REPRESENTATIVE: *(Not required for surviving spouses)*

This is to confirm that _____ is a member in good standing with
(Name of Applicant)

Union Local # _____ Yes/No: _____

_____ _____ _____
Signature of Local Union Representative Printed Name: Date:

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