

**APPLICATION FOR COVERAGE AS A RETIREE
UNDER THE RETIRED SAN MATEO ELECTRICAL WORKERS
HEALTH CARE BENEFITS PLAN (IBEW Local 617)**

I hereby make application to the Retired San Mateo Electrical Workers Health Care Benefits Plan (IBEW 617). This application is used to establish plan eligibility only, and is not a health care plan enrollment form. Health care plan enrollment forms and information will be sent to you after you have been approved for retiree benefits.

Name _____ Social Security Number _____
 Address _____ City _____ Zip _____
 Phone Number _____ Pension Retirement Date _____
 Date of Birth _____ Health & Welfare Retirement Date _____
 Requested Date of Retirement * _____
 Last Date Worked _____

* Your requested date of retirement can be no sooner than the first day of the third month following the date the completed application is received by the Administrative Office.

Spouse's Name _____
 Spouse's Date of Birth _____ Spouse's Social Security # _____

I Certify the following:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. I have been eligible under the San Mateo Electrical Workers Health Care Benefits Plan for 10 of the last 15 years and 2 of the last 5 years immediately preceding date of retirement. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I had/will have coverage under the San Mateo Electrical Workers Health Care Benefits Plan as of my retirement date. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. When eligible, I will apply for and receive Medicare Parts A and B. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I am at least 55 years of age and eligible to retire under the Pension Plan. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I am currently receiving disability benefits. | <input type="checkbox"/> | <input type="checkbox"/> |

I understand that instead of Retiree Coverage, I may self-pay to extend my active plan coverage for a limited time under the federal law known as COBRA. The monthly cost for this coverage will be determined by the Trustees and will end after 18 months as required by COBRA. By applying for the Retiree Plan, I am waiving my rights to COBRA coverage. I also understand if I return to work after retiring, I am only eligible for a total of 40 hours maximum per month towards my Health & Welfare. I **WILL NOT** get Health & Welfare credit for any hours worked over 40 hours in one month.

Retiree Signature _____ Date _____

Please select the health care plan for which you would like to receive information and an application. You will not be enrolled in a health care plan until you have completed and returned the health care plan application to the Retiree Administrative office, and have been approved by the health care plan provider.

Retiree- Medicare Blue Shield Kaiser
 Early Retiree-Non Medicare Self Funded Kaiser

FOR ADMINISTRATIVE USE ONLY

Application Approved _____ Authorized By: _____
 Retirement Date _____ / _____ / _____ Date: _____
 Application Denied _____ Sent to Retiree Trust: _____

RETURN THIS APPLICATION TO UNITED ADMINISTRATIVE SERVICES

White – LAS Canary – VRI Pink – Local 617 Union Office Goldenrod – Participant

