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. _____ City_____ Zip _____

Address. _____ Pension Retirement Date._____

Phone Number _____ Health & Welfare Retirement Date _____

Date of Birth_____ Requested Date of Retirement *_____

Email _____ Last Date Worked_____

Social Security Number _____

* 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	☐	☐
2. 10 of the last 15 years and 2 of the last 5 years immediately preceding date of retirement.	☐	☐
3. I had/will have coverage under the San Mateo Electrical Workers Health Care Benefits Plan as of my retirement date.	☐	☐
4. When eligible, I will apply for and receive Medicare Parts A and B.	☐	☐
5. I am at least 55 years of age and eligible to retire under the Pension Plan.	☐	☐
6. I am currently receiving disability benefits.	☐	☐

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 ☐ Hartford

Early Retiree – Non Medicare ☐ Self-Funded ☐ Kaiser

FOR ADMINISTRATIVE USE ONLY

Application Approved _____ Authorized By: _____

Retirement Dated: _____ Date: _____

Application Denied _____ Sent to Retiree Trust: _____

RETURN THIS APPLICATION TO UNITED ADMINISTRATIVE SERVICES