



Eighth District Electrical Fringe Benefit Funds



Dear Eighth District Electrical Retiree

The Trust Fund Office received notification that you will be retiring soon. In order to enroll under the Retiree Health Care Plan, you must meet the Retiree Eligibility requirements and you must return the application to enroll in the Retiree Health Care Plan no later than the fifteenth (15th) day of the month following the month in which you lost eligibility under the eligibility rules of the Medical Plan for Active Employees. Retiree coverage must be continuous immediately following the loss of eligibility. The requirements can be found in the Summary Plan Description Booklet.

You are eligible as a retired Employee:

1. If the Employee retires between the ages of fifty-five (55) and sixty (60), the employee must have participated in the Medical Plan as an Active Employee for:
 - a. Five (5) of the last seven (7) years immediately prior to retirement; and
 - b. A minimum of twenty (20) years.
2. If the Employee retires at age sixty (60) or older, the employee must have participated in the Medical Plan as an Active Employee for:
 - a. Five (5) of the last seven (7) years immediately prior to retirement; and
 - b. A minimum of ten (10) years.
3. An Employee may participate as an Early Retiree, if the Employee becomes totally disabled as a result of work for a Contributing Employer, in accordance with these provisions:
 - a. Total disability commenced after July 1, 2011
 - b. The Active Employee has participated in the Medical Plan for at least twenty (20) years and is at least 50 years of age on the date of total disability.
 - c. This Plan requires that the disabled Employee make application to the Social Security Administration for permanent disability.
 - d. If a permanent disability award is received from the Social Security Administration within 29 months of the date the Employee is accepted as an Early Retiree under this Plan, then the disabled individual can continue coverage under this Plan until the "Termination or Retiree Eligibility" provisions of the Plan are met.
 - e. If a permanent disability award is not received from the Social Security Administration within 29 months of the date the Employee is accepted as an Early Retiree under this Plan, then the disabled individual can continue coverage under this Plan as an Early Retiree (in lieu of electing COBRA continuation coverage) only for the total of 29 months.

You will be eligible to continue the Health and Welfare coverage through the Eighth District Electrical Fringe Plan if all the requirements are met.

If approved to continue your coverage on the Retiree Health Care Plan, you will be required to make a monthly premium. The Retiree premium is due by the 1st of the month for which coverage is intended and will be considered timely within 30 days of the due date. If you fail to make the required contributions to the Fund in a timely manner, your coverage will terminate on the first day of the month in which the contribution was due.

Should you have any questions, please do not hesitate to contact the Trust Fund Office at the phone number listed below.

Sincerely,

Eighth District Electrical Fringe Benefit Funds

Physical Address: 5295 South Commerce Drive, Suite 220 • Murray, UT 84017

Mailing Address: P.O. Box 30751 • Salt Lake City, UT 87130-0751

Toll Free: 844-989-2321

www.8thDistrictBenefits.org



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RETIREE HEALTHCARE APPLICATION

I Have Retired or Plan to Retire On: _____

Retiree's Name: _____ SSN: _____

Retiree Birth Date: _____ Are You Eligible For Medicare? _____ Yes _____ No

Spouse's Name: _____ SSN: _____

Spouse's Birth Date: _____ Is Spouse Eligible for Medicare? _____ Yes _____ No

**** If eligible for Medicare, please include a copy of Medicare card ****

Address: _____
Street

City _____ State _____ Zip _____

Phone Number: _____ E-Mail: _____

<u>MEDICAL PLAN</u> (Provided By): CIGNA <u>PRESCRIPTION</u> (Provided By): EXPRESS SCRIPTS	<u>DENTAL</u> (Provided By): METROPOLITAN LIFE INSURANCE	<u>VISION</u> (Provided By): SELF-FUNDED PLAN
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PLEASE LIST ALL DEPENDENTS (INCLUDING SPOUSE) THAT WILL CONTINUE ON THE RETIREE PLAN:

1. _____
2. _____
3. _____

TO CONTINUE COVERAGE ON THE PLAN, PLEASE SIGN BELOW:

I, _____, hereby elect to enroll to the Eighth District Electrical Health and Welfare Plan for participation in the Retiree Program. I agree to notify the Administrator of the Fund whenever I return to work in the industry. I also agree that my participation is to be governed in all respects by the provision of the Fund, or as the same may hereafter be amended, and the making of any monthly payment by me in the amount and manner as established by the Fund.

Participant's Signature _____

Date _____

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Eighth District Health & Welfare Plan Automatic Pension Deduction for Monthly Retiree Self Payment Form

The BEST way to pay your Monthly healthcare premium....

And here's why...

Automatic pension deduction is *safe* because you're monthly Retiree self-payment is automatically deducted from your pension check – no more worrying about lost or stolen checks or delays caused by mail service.

Automatic pension deduction is *easy* because your Retiree self-payment is deducted from your pension check on time, correctly and confidentially. No more worries about termination of your healthcare eligibility for late payments or lost checks.

Please take a few minutes and complete the form on the back so you can take advantage of the benefits of automatic pension self-payment deduction. It will take the Benefit Office about 30 days after it receives your authorization to set up the procedure with your bank. Please be assured there will be no interruption in your healthcare benefits and there is no cost to you.

Mail to:

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Salt Lake City, UT 87130
Phone 844-989-2321

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SELF PAYMENT PENSION DEDUCTION AGREEMENT

Name of Participant: _____ Social Security No: _____

Address: _____

City: _____ State _____ Zip _____

Telephone No: () _____ Email: _____

I, the undersigned, am receiving a monthly benefit from the Eighth District Pension Plan and wish to have a portion of that benefit used to maintain eligibility for benefits under the Eighth District Health & Welfare Plan for the coverage which I have selected. For that purpose, I hereby assign whatever amount may be required from time to time to maintain that coverage under the Health and Welfare Fund as reported to the Pension Fund by the Health and Welfare Plan and authorize the Pension Fund to deduct that amount from my monthly benefit check and remit it directly to the Health and Welfare Plan.

I understand that I may rescind this authorization at any time by notifying the Pension Fund Office, in writing, at least sixty days before the effective date of the rescission.

Signature: _____ Date: _____

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Retiree Option for COBRA Coverage

When you retire, we must by Law offer you COBRA whether or not you qualify to participate in the Retiree Health Care Program. Retirement is considered to be a termination of employment. As an active employee, your coverage is paid by your employer, but as a retiree you pay for your coverage. This is considered a loss of coverage. The combination of termination of employment and loss of coverage makes retirement a “qualifying event”.

If you do not qualify to participate in the Retiree Health Care Program, electing COBRA will allow you to continue your coverage for up to 18 months while you seek other long-term health care coverage.

If you do qualify to participate in the Retiree Health Care Program, you are offered a choice between electing COBRA for up to 18 months or participating in the Retiree Program. The reason you must be offered the choice is, the cost of the retiree health care coverage is your responsibility and comes out of your pocket. The coverage you had as an Active employee was paid by your employer. This is considered to be a loss of group health coverage because the coverage is no longer provided under the same terms and conditions as it was prior to retirement.

In addition, COBRA allows the retiree 60 days to elect coverage and an additional 45 days from the election date before the first payment must be made. Once a COBRA election is made, payments are due the 1st day of the month of coverage, but there is also a 30-day grace period. Retiree self- payments are due by the 1st day of the month for which coverage is intended and will be considered timely if received within 30 days of the due date.

If you have any questions, please contact the Benefit Office at the phone number listed below.

Sincerely,

Eighth District Electrical Fringe Benefit Funds