Central Midwest Regional Council of Carpenters'
Welfare Fund

P.O. Box 1257, Troy, MI 48099
(800) 700-6756
www.cmrccbenefits.org

RETIREE HEALTH CARE PREMIUM
PENSION CHECK DEDUCTION AUTHORIZATION

PARTICIPANT INFORMATION

Participant Name:	
BeneSys Alternate ID:	
Street Address:	
City/State/ZIP:	
Telephone Number:	
Email Address:	

PENSION FUND SELECTION

☐ Ohio Carpenters Pension Fund
☐ Southwest Ohio Regional Council of Carpenters Pension Fund
☐ Indiana State Council of Carpenters Pension Fund
☐ Mid-America Carpenters Regional Council Pension Fund (Formerly IKORCC Pension)

AUTHORIZATION

I authorize the Pension Fund selected above to deduct the amount required to pay my retiree health care premium from my monthly pension benefit and remit that amount directly to the Central Midwest Regional Council of Carpenters Welfare Fund ("Welfare Fund"). I understand premium amounts may change and authorize deduction of future revised premium amounts without a new authorization. I acknowledge that this authorization is voluntary.

INFORMATION SHARING

In order to facilitate the deduction from the Pension Fund to the Welfare Fund, the following information will be shared with the Pension Fund from the Welfare Fund: (1) Name; (2) Address; (3) DOB; (4) SSN; and (5) premium amount.

HIPAA AUTHORIZATION

By signing below, I authorize the Welfare Fund, including its Plan Administrator, to use and disclose the information described in the "Information Sharing" section above to the Pension Fund I have selected on this form, and its Plan Administrator, for the sole purpose of establishing and administering the deduction of my retiree health care premium from my monthly pension benefit and remitting that amount to the Welfare Fund.

I understand and agree that:

- This authorization is voluntary, and the Welfare Fund will not condition my eligibility for benefits on whether I sign it; however, the premium-deduction arrangement described on this form cannot be implemented without it.
- I may revoke this authorization at any time by providing written notice to the Welfare Fund as described in the "Rescission of Authorization" section below, except to the extent the Welfare Fund or the Pension Fund has already taken action in reliance on it.
- This authorization will remain in effect until I revoke it in writing or until I am no longer eligible to participate in the premium-deduction arrangement, whichever occurs first.
- Information disclosed under this authorization may be redisclosed by the Pension Fund and may no longer be protected by the federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I am entitled to receive a copy of this signed authorization.

RESCISSION OF AUTHORIZATION

I understand that I may revoke this authorization at any time by providing written notice to the Pension Fund (in care of the Welfare Fund) at least sixty (60) days before the desired effective date of termination. The Pension Fund will discontinue the deduction arrangement as soon as administratively feasible after receiving notice.

PARTICIPANT CERTIFICATION & SIGNATURE

I certify that the information provided on this form is true and accurate and that I have read and understand the terms of this authorization. I have read, understand, and agree to the terms of this authorization, and I execute it voluntarily and knowingly.

Participant Signature: _____ **Date:** _____