



HARRISON TRUST
A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

**HARRISON ELECTRICAL WORKERS TRUST FUND
HEALTH PLAN RESERVE ACCOUNT SHARING
RECIPIENT APPLICATION FORM**

The purpose of the Health Plan Reserve Account Sharing Policy (the Policy) is to permit Participants of the Harrison Electrical Workers Trust Fund Active Employee Plan (the Plan) to assist other Participants who would lose coverage under the Plan but for receiving transferred credit dollars from other Participants.

The minimum donation of credit dollars is equal to 40 hours of contribution. There is no maximum.

Instructions: Please list your name, as a participant who is applying to receive donated reserve account credit dollars. Then sign the acknowledgment below and return to the Administrative Office.

Print Applicant Name: _____

Acknowledgment

I am the above participant who is applying to receive a donation of reserve credit dollars to my Plan reserve account. I have received and read the Health Plan Reserve Account Sharing Policy and agree to the terms of the Policy. I am affirming that I have not and will not provide anything of value in exchange for the donated credits. I am verifying that I do not have coverage under another individual or group health plan. I understand that for my account to receive the donated credit dollars, I must be eligible to make partial self-payments or COBRA payments under the Plan. The donated credits will be used to provide coverage for me for the first month in which sufficient credits are donated to purchase a month of coverage for me and for each month thereafter in which there are sufficient credits to provide me with coverage under the Plan. I understand that the donated credits may only be used to provide coverage for me, and that any unused credits will remain in my reserve account and may be forfeited as provided in the Plan.

Signed: _____

Date