



## EARLY RETIREE PLAN APPLICATION

# HARRISON TRUST

A FAMILY HEALTH PLAN

WWW.HARRISONBENEFITS.ORG

Return to: PMB#116  
5331 S Macadam Ave Suite 258  
Portland, OR 97239  
In Portland: 224-0048  
Toll Free: 1-800-547-4457

Each employee who seeks coverage under the Early Retiree Plan must complete ALL the information requested below. If any item is not applicable, write "N/A". If more space is needed, attach an additional sheet of paper.

Full Name (Please Print)

Social Security Number

Permanent Address

Date of Birth

Permanent Address

(      ) Telephone Number

Local Union: \_\_\_\_\_

1. Please indicate the last date you will work in the electrical industry: \_\_\_\_\_

2. Have you applied for social security benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

**If your answer is yes, attach a copy of your application form.**

3. Have you applied for, or are you receiving a pension from a pension plan sponsored by a local union affiliated with the IBEW? Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer is yes, give the name of the pension plan.

(i.e., Edison Pension, Cornell Pension, Cascade Pension) \_\_\_\_\_

4. Have health insurance contributions been made on your behalf to the Harrison Trust by an employer at any time after January 1, 1992? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Give the name of your most recent employer in the electrical industry: \_\_\_\_\_

6. List the month and year you want to begin enrollment in the Early Retiree Plan:

\_\_\_\_\_

If you have a spouse or domestic partner you want to enroll in the Early Retiree Plan, complete questions 7 through 9 below.

7.  Spouse/Domestic Partner Name (Please print)  Spouse/Domestic Partner Date of Birth

Spouse/Domestic Partner Social Security Number

8. Is your spouse/domestic partner currently covered under Medicare? Yes  No

9. Is your spouse/domestic partner currently covered under another group health insurance plan? Yes  No

If your answer is yes, please complete the following information:

a. Name of insurance carrier:

b. Policy No.:

c. Persons covered under your spouse/domestic partner plan

---

10. If you have dependent children you want to enroll in the Early Retiree Plan, please complete the questions below.

Relationship (Natural, adopted, step)

Name  Date of Birth  Gender

Name  Date of Birth  Gender

11. Are the dependents listed above enrolled in or eligible to enroll in an employer sponsored health plan other than a group health plan of a parent? Yes  No

**Payment Options:** Autopay  Edison Pension Deduction  Direct Bill   
(If you selected Autopay or Edison Pension Deduction, please complete and attach the applicable form)

**I, retired member, certify the answers to the questions on the application form are true and correct.**

**(Date)**

**(Sign Name)**