



SOLANO AND NAPA COUNTIES ELECTRICAL WORKERS BENEFIT FUNDS



RETIREE HEALTH CARE

You may be eligible for retiree health care coverage under the Solano-Napa Counties Electrical Workers Local 180 Retiree Health Care Plan. You must meet the requirements of the Summary Plan Description Booklet to be eligible for coverage.

Would you like to continue coverage under the Retiree Health Care Plan?

_____ YES _____ NO (Please sign below to waive coverage)

Please list the dependents that will continue on your plan:

1. _____ 2. _____
3. _____ 4. _____

Are you, your spouse or dependents on Medicare? _____ YES _____ NO

If you answered yes, please include a copy of the Medicare card – Must have Medicare Parts A & B

AUTHORIZATION FOR SELF PAYMENT DEDUCTION

Please reduce my monthly Pension check by the amount of my monthly self-payment, in order to continue my benefits in the Solano-Napa Counties Electrical Workers Local 180 Health Care Plan. This amount is to be applied against my self-payment contribution to the Insurance Fund.

Date

Signature

Social Security Number

YOU MUST NOTIFY THE FUND OFFICE OF ANY CHANGES FOR YOUR INSURANCE. AN EXAMPLE WOULD BE WHEN THE MEMBER OR SPOUSE BECOMES EFFECTIVE FOR MEDICARE BENEFITS.

DO NOT SIGN BELOW THIS LINE IF YOU WISH TO CONTINUE COVERAGE

WAIVER ELECTION

I wish to terminate my Health Insurance benefits with the Solano-Napa Counties Electrical Workers Local 180 Health Care Plan as of _____, 20___. I realize that this form serves to waive any liability that the Solano-Napa Counties Electrical Workers Local 180 Health Care Plan might have and the specific Health Insurance Company that I currently have a policy with. I am waiving my right to have the health insurance at this time, and realize that reinstatement for coverage may only be done in accordance with the Plan rules and regulations. **If you wish to delay coverage at this time please provide proof of current coverage under your spouse's group plan.**

Date

Signature

Social Security Number

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