IBEW LOCAL 595 TRUST FUNDS

IBEW LOCAL 595 HEALTH & WELFARE PLAN
AUTHORIZATION TO DEDUCT "BUY UP" AMOUNT FROM HRA ACCOUNT

Member Name: _____

Social Security #: _____

Address: _____

_____

My signature below is authorization to have the monthly Buy Up amount ($279.50) currently required for continued enrollment in UnitedHealthcare HMO or the Blue Cross PPO (Self-Funded Indemnity Plan) deducted from my Health Reimbursement Account (HRA). I understand that the Buy Up amount may change in the future and that this authorization will also apply to any such changed amount. I understand that this monthly deduction from my HRA will continue under the terms of the IBEW Local 595 Health & Welfare Plan rules.

PLEASE BE ADVISED THAT IF YOU CHOOSE TO USE YOUR HRA TO MAKE YOUR PAYMENT, YOU WILL BE CHARGED THE FULL BUY UP AMOUNT (CURRENTLY $279.50). IF YOUR HRA ACCOUNT FALLS BELOW THE BUY UPAMOUNT YOU WILL BE BILLED FOR THE ENTIRE AMOUNT.

****** PLEASE NOTE THAT IF YOU ARE BILLED FOR THE BUY UP AND YOU DO NOT PAY BY THE DUE DATE, YOUR COVERAGE WILL TERMINATE FOR YOUR CURRENT HEALTH COVERAGE AND YOU WILL BE PLACED IN THE PLAN'S DEFAULT OPTION. ******

This authorization will remain in effect until you submit a written statement to the Trust Fund Office rescinding this authorization.

_____ _____

Member's Signature Date

_____

Member's SS#

Please return this form to: IBEW Local 595 Health & Welfare Plan
P.O. Box 3420
San Ramon, Ca 94583