

Iron Workers St. Louis District Council Trust Funds

P.O. Box 1096·Maryland Heights, MO 63043·Phone 314.656.1091·Toll Free 877.597.8704·Fax 314.739.1105

AUTHORIZATION FOR HEALTH AND WELFARE COVERAGE DEDUCTION

Please reduce my monthly Pension check in the amount of my monthly Health and Welfare Coverage premium in order to continue my benefits through the Iron Workers St. Louis District Council Health & Welfare Fund.

Date _____ **Payee's Authorized Signature** _____

Payee's Social Security Number _____ **Participant's Name – PLEASE PRINT** _____

PLEASE NOTE: If you have specific questions regarding your account, please contact the Benefit Office at 877-597-8704.

YOU MUST NOTIFY THE BENEFIT OFFICE OF ANY CHANGES THAT WOULD AFFECT YOUR COVERAGE. AN EXAMPLE WOULD BE IF YOU OR YOUR SPOUSE BECOMES ELIGIBLE FOR MEDICARE BENEFITS.

WAIVER ELECTION

I do not wish to have my monthly premium deducted from my monthly pension check. I wish to send my monthly self-payment to Iron Workers St. Louis District Council Health & Welfare Fund by mail. I understand that premiums for Health and Welfare Coverage must be paid the 20th of the month prior to the coverage month.

EXAMPLE: February coverage must be paid by January 20th.

Date _____ **Payee's Signature** _____

Payee's Social Security Number _____ **Participant's Name – PLEASE PRINT** _____

PLEASE NOTE: If at a later date you wish to have your monthly self-payment deducted from your pension check, please contact the Benefit Office at 877-597-8704 to request an Authorization for Health & Welfare Coverage Deduction Form.