PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

SELF-PAYMENT ELECTION FORM
(MUST be returned to the Trust Fund Office with Payment)

Name:_____ Soc Sec No:_____

Telephone Number:_____ Date of Birth:_____

_____ _____
Name of Applicant for Continuation Relationship to Employee

_____ _____
Applicant's Street Address or P.O. Box Number Date of Qualifying Event

_____
Applicant's City/State/Zip Code

I elect: Self-payment Coverage for **a maximum payment of $7,000.00 (12 MONTH PERIOD)**, at the end of which if I have not regained eligibility, I have the option of electing COBRA continuation.

The SELF-Payment amount is equal to the "Cost of Coverage" based on elected Medical & Dental carriers. Furthermore, you have the option of using the dollar bank balance as partial payment towards the continuation of coverage. The amount due reflected on the enclosed self-payment notice is your current cost of coverage less your dollar bank balance.

If you wish to make payments for the continuation of coverage based on the "cost of coverage", you are required to complete & return this form to the Trust Fund office along with your payment.

I understand that I must notify the Trust Fund Office immediately when anyone under continuation coverage first becomes covered under Medicare or another Group health plan. I also must notify the Trust Fund Office within 60 days after the employee divorces or a dependent child loses dependent status.

I also understand that is Social Security determines me or a dependent to be disabled at the time my employment terminated or hours were cut back, the disabled person is entitled to extend coverage an additional 11 months beyond the 18 months, provided that I notify the Trust Fund Office within 60 days of the Social Security determination and before the end of the first 18 months of coverage.

_____ _____
Signature of Applicant Date

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