



BRICK MASONS TRUST FUNDS

Bricklayers Local No 4 Southern California

RETIREE HEALTH CARE PLAN ELECTION FORM

Election of MEDICAL BENEFITS (choose only one):

- ☐ PacifiCare HMO
- ☐ Kaiser Permanente HMO
- ☐ Kaiser Senior Advantage - (Medicare eligible members only)

Waiver of Election of Retiree Health Care Coverage

- ☐ I Decline to elect Health Care Coverage under the Brick Masons Retiree Health Care Plan.

If you are under age 65 and or not entitled to Medicare Parts A and B you may elect Retiree Healthcare Coverage under PacifiCare HMO or Kaiser HMO only. If you are over age 65 or entitled to Medicare Parts A and B you must elect coverage under Kaiser Senior Advantage.

If you are Medicare eligible please contact the Trust Fund Office to request a Kaiser Senior Advantage Enrollment Packet.

By signing this form, I acknowledge that I have reviewed the enclosed information and understand that I must use providers (doctors, hospitals etc.) that participate in the Plan I have chosen. I understand that I may be responsible for payment on any and all expenses, including deductibles and co-pays that are not covered when I do not use a participating provider. I also understand that my election cannot be changed.

If you have chosen to waive and decline the election Retiree Health Care Coverage under the Brick Masons Retiree Health Care Plan by law you will still be offered COBRA Continuation Coverage as explained in the enclosed Retiree Option for COBRA Coverage letter.

Participant's Name _____

Participant's Signature _____

Participant's Social Security # _____

Date _____

Mailing Address: P.O. Box 430 • West Covina, CA 91793
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