UA Local 190 Health and Welfare
IHRA PRE Authorization

Member Name: _____

Last Four Digits of SSN: XXX-XX-_____

I understand that to continue eligibility in the UA Local 190 Health and Welfare Health Fund I must work 100 hours per month. I further understand that I will not have any coverage for medical expenses incurred after the month that follows the month in which I have less than 100 hours in covered employment unless I make a self-payment.

The Plan offers two different self payment options to prevent loss of coverage because of the 100 hour rule.

A. The first option provides for "lower payments" (as compared to the full COBRA rate) in the 12 month period following loss of coverage. This plan is only available for Members who are available for work (i.e. on the "on the out of work" list), who make the self –payments on time as required by the Plan and are in good standing with the Union.

B. The second option is "COBRA " with much higher premiums. This option is the "last chance" for those who don't qualify for the lower self payments, fail to make timely self payments, exhaust the 12 month period provided under the self – payments plan or lose coverage for another qualifying event.

❑ I authorize the UA Local 190 Health and Welfare Fund to automatically withdrawal monies from my IHRA Fund account to pay my monthly self—pay if there hasn't been another payment made by the last day of the month in which self-payment is due.

❑ I understand that I may revoke this authorization at any time, by giving written notice to:

UA Local 190 Health and Welfare Fund
P.O. BOX 110
St. Clair Shores, MI 48080
Fax: 734.424.0974 Email: asolanskey@ua190.org

Member Signature: _____ Date: _____

Witness Signature: _____ Date: _____