U.A. Local No. 393 Benefit Funds
PLUMBERS, STEAMFITTERS & REFRIGERATION FITTERS
1731 Technology Drive, Suite 570 ■ San Jose, CA 95110
P.O. Box 2460 ■ San Jose, CA 95109-2460
Phone (408) 588-3751 ■ Fax (408) 436-8210

Election Form for Retiree Medical/Dental Coverage

Name: _____ Social Security No.: _____

Date of Birth: _____ Date of Retirement: _____

I understand that I must complete this two page form entirely to be eligible for coverage. I further understand that when I or my dependent spouse first become eligible for Medicare that I/we must apply for and maintain both Part A and Part B in order to remain eligible for coverage.

MEDICAL: ☐ **ELECT** ☐ **DECLINE** ☐ **DEFER** (I have attached a copy of my other group health coverage)
I understand that by choosing Retiree Medical Coverage, I am responsible to pay the required monthly premium. I also understand that if I do not elect and pay for Medical coverage, it will **not** be offered to me again. I also agree to apply for and have my dependent spouse apply for and maintain both Medicare Part A and Part B. I understand that if I/we do not maintain both Medicare Part A and Part B when I/we are eligible to do so, I/we will **NOT** be eligible to participate in the Health and Welfare Plan. **Note**: Participants are eligible to defer or suspend their coverage in the retiree healthcare plan one time. In order to reinstate retiree healthcare coverage at a later date, the participant must provide proof of continuous coverage since leaving the Plan.

_____ _____
Signature Date

DENTAL: ☐ **ELECT** ☐ **DECLINE** ☐ **DEFER** (I have attached a copy of my other group health coverage)
I understand that by choosing Retiree Dental Coverage, I am responsible to pay the required monthly premium. I agree to continue Retiree Dental Coverage for at least twelve months following retirement.

_____ _____
Signature Date

Deduction from Extended Reserve Account:
I elect to have my monthly payment for coverage deducted from my Extended Reserve Account until it is exhausted or until I cancel the automatic deductions in writing.

_____ _____
Signature Date

Direct Debit from Bank Account:
I elect to have my monthly payment for coverage deducted from my bank account and have completed the Authorization Agreement for Direct Payments.

_____ _____
Signature Date

Medicare Questionnaire

Please check all of the following that apply to you and/or your dependent spouse:

☐ I will send a copy of my Medicare card and/or my spouse's Medicare card upon receipt of Medicare coverage.

☐ I have Medicare coverage that became effective _____

☐ My spouse has Medicare coverage that became effective _____

☐ I have attached a copy of my and/or my spouse's Medicare card.

☐ I do not have Medicare coverage, but expect to receive it _____

☐ My spouse does not have Medicare coverage, but expects to receive it _____

_____ _____

Signature Date

Please return this form to:

U.A. Local No. 393 Benefit Fund Office
P.O. Box 2460
San Jose, CA 95109