

# ELECTION FORM – MICHIGAN CARPENTERS' HEALTH CARE FUND

I have read and understood the provisions for continuing coverage. I have checked the type of coverage elected below. I understand that no Death Benefits of any type are provided with COBRA Continuation Coverage. I also understand that, if COBRA Continuation Coverage is elected, it may not be changed at a later date. However, should I initially elect Self-Contribution coverage, I may at a later date change my coverage to **Alternative Minimum Coverage** by submitting a new Election Form. I also understand that I may **not** revert to Self-Contribution Coverage following election of Alternative Minimum Coverage. (It is the intent of the Board of Trustees to review the Self-Contribution, Alternative Minimum Coverage Self-Payment, and COBRA Continuation coverage rates and make appropriate adjustments on a continuous basis.)

Are you or any of your dependents currently covered by another group health care plan(s)? YES \_\_\_ NO \_\_\_

If yes, list names of dependents covered by the other plan(s): \_\_\_\_\_

\_\_\_\_\_

If YES, indicate name(s) of plan(s): \_\_\_\_\_

Are you or any of your dependents currently eligible for Medicare benefits? YES \_\_\_ NO \_\_\_

I elect to purchase the coverage checked below:

## SELF-CONTRIBUTION COVERAGE

\_\_\_ Health Care Benefits at the rate of **\$413.00** per month. (140 hours at \$2.95 per hour)

## ALTERNATIVE MINIMUM COVERAGE

\_\_\_ In-Patient Benefits, OutPatient Surgery Benefits at 80%, Diagnostic X-Rays and Laboratory Benefits **ONLY**, at the rate of **\$221.00** per month.

## COBRA CONTINUATION COVERAGE

\_\_\_ Health Care Benefits **ONLY**, at the rate of **\$450.31** per month.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Amount Enclosed

\_\_\_\_\_  
Name of Participant (Please Print)

\_\_\_\_\_  
Date Signed

List Individuals to be Covered (Use reverse side, if necessary)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_

\_\_\_\_\_

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