

**SUPPLMENT TO MEDICARE ELECTION FORM  
MICHIGAN CARPENTERS' HEALTH CARE FUND**

I have read and understood the provisions for continuing coverage. I have checked the type of coverage desired below. I understand that, once a type of coverage is elected, it may not be changed at a later date. I also understand that no Death Benefits of any type are provided with COBRA Continuation Coverage.

**THIS FORM MUST BE COMPLETED AND RETURNED IN ORDER TO BE ELIGIBLE FOR COVERAGE**

It is the intent of the Board of Trustees to review these rates and make appropriate adjustments on a regular 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 desire to purchase the coverage listed below:

**SUPPLMENT TO MEDICARE COVERAGE**

\_\_\_\_\_ Member with Medicare (one person only) for Health Care and Flex Benefits at the rate of \$159.00 per month.

\_\_\_\_\_ Member with Medicare—On Supplement to Medicare Program, spouse (and dependents) without Medicare—On Full Coverage \$693 per month

\_\_\_\_\_ Member with Medicare—On Supplement to Medicare Program, spouse (and dependents) without Medicare—On Alternative Minimum Coverage \$501 per month. (See enclosed Benefits at a Glance for benefits)

**DECLINATION OF COVERAGE**

\_\_\_\_\_ I do not desire to purchase either COBRA Continuation Coverage or Totally & Permanently Disabled coverage.

\_\_\_\_\_  
Signature of Participant Social Security Number

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

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

List individuals to be covered (use reverse side, if necessary):  
Name Relationship Date of Birth

\_\_\_\_\_  
\_\_\_\_\_