RETIREE 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, 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. It is the intent of the Board of Trustees to periodically review these rates and make appropriate adjustments.

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

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 ☐ If yes, please send a copy of your Medicare card.

I elect to purchase the coverage listed below (CHOOSE ONLY ONE):

EARLY RETIREE SELF-PAYMENTS –Full Coverage *

______ Health Care Benefits at the rate of **$693.00** per month

ALTERNATIVE MINIMUM COVERAGE

______ Basic Services Only (See Benefits at a Glance to see what is covered) at the rate of **$342** per month

COBRA CONTINUATION COVERAGE (Limited to 18 months only. Not eligible if you have any other coverage)

______ Health Care Benefits **ONLY** at the rate of **$627.65**, per month.

DECLINATION OF COVERAGE

______ I do not desire to purchase Self-Contribution coverage, COBRA Continuation Coverage or Alternative Self-Contribution coverage.

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

*For rates for Disabled members or members with Medicare, please contact the Fund Office.