

**TOTALLY & PERMANENTLY DISABLED 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:

COBRA CONTINUATION COVERAGE (Maximum of 36 months only. Not eligible if have any other coverage.)

_____ Health Care Benefits **ONLY** at the rate of **\$627.65** per month.

TOTALLY & PERMANENTLY DISABLED COVERAGE

_____ Member without Medicare, with or without dependents for 1st six months of Health Care at the rate of **\$405.00** per month. Effective with the 7th month and after the rate will be **\$693.00** per month.

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

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

