Teamsters Western Region & Local 177
Retiree Health Care Plan

P.O. BOX 43110 PHOENIX, AZ 85080-3110
TOLL FREE: (855) 215-2039 FAX: (602) 324-0555
WWW.WR177HEALTHCARE.COM

RETIREE MEDICAL PLAN APPLICATION

ELIGIBILITY RULES & INSTRUCTION GUIDE

(FOR RETIREES WHO RETIRE ON OR AFTER JANUARY 1, 2014)

Dear Retiring Member: Congratulations on your retirement! This instructional guide is provided to help you understand when, how and what paperwork is needed to bridge your Active Plan coverage to your Retiree benefits with no break in healthcare coverage for you and your family. To begin the process, please review this informational guide and then complete the Retiree Medical Plan Application-Deferral Form.

The Retiree Plan provides a comprehensive benefit package including medical, prescription drug, dental and vision benefits at a low monthly premium. To be eligible for the Retiree Plan, you must apply within 60 days of retirement or forfeit participation in the Retiree Plan. You also must meet the following eligibility rules depending on which region or pension plan you retired from:

A. Western Region:

(Phone # for assistance with Western Region Pension Fund: 1-800-845-4162):

	Yes	No
1. You participated in the Active Plan (or a predecessor) for 30 of the 48 months (130 weeks of the 208 weeks) preceding retirement and;	☐	☐
2. You had at least 10 years of employment with a contributing employer to The Teamsters Western Region & Local 177 Health Care Plan and are eligible & retire under a disability pension, normal and/or PEER pension from the Western Conference of Teamsters Pension Fund.	☐	☐

B. Teamsters Local 177:

(Phone # for assistance with Teamsters Local 177 Pension Fund: 1-800-643-4442):

1. You are eligible and begin receiving a pension based on the early or normal provisions of the Local 177/UPS Pension Plan or the UPS Part-Time Pension Plan and (in addition) meet one of the following criteria:	☐	☐

- At any age with 30 or more years of credited service;
- At age 50 or more with 25 or more years of credited service or
- At age 55 or more with 20 or more years of credited service.

ELIGIBILITY RULES & INSTRUCTION GUIDE (CONT.)

C. Voluntary One-Time Deferral Option:

1. All retiring members and their spouses are eligible for a one-time deferral of benefits under this Retiree Plan at any time if documentation of other health benefit coverage can be provided during the deferral period.

   If you are deferring participation under the Retiree Health Plan, you must provide proof of other health coverage and the effective date of such coverage. When you re-enter participation into the Retiree Health Plan, you must provide proof of other health coverage for the entire deferral period.

D. Eligibility for Dependents:

1. Eligibility for all persons listed shall be subject to all provisions and limitations of the Trust Agreement and Plan Document as well as to any rules or regulations adopted by the Board of Trustees. Please see your Summary Plan Description for a full explanation.

2. Coverage for a dependent child terminates at age nineteen (19). Coverage can be continued until age 25, provided the dependent is attending college or an accredited school as a Full Time Student. The Full Time Student Status form can be found on the website at www.wr177healthcare.com. Full Time Student Status must be verified each semester in order to continue coverage.

3. Newly acquired Spouses cannot be added to this Retiree Plan after your initial enrollment.

4. Subsequent changes to you or your dependents coverage can only be made during Open Enrollment. The only exception to this rule is in the case of qualifying Life Events such as marriage, divorce, death, birth, adoption (or placement for adoption) or loss of health coverage. All changes made due to qualifying Life Events must be submitted within sixty days of the qualifying Life Event.

RATES: (BELOW ARE THE SELF-PAY MONTHLY RATES)

NON-MEDICARE ELIGIBLE (WITH NON-MEDICARE ELIGIBLE SPOUSE/PRIMARY DEPENDENT)	RETIREE WITH SPOUSE/DEPENDENT(S) WHERE ONE IS NON-MEDICARE ELIGIBLE & THE OTHER PRIMARY DEPENDENT IS MEDICARE ELIGIBLE	MEDICARE ELIGIBLE (WITH MEDICARE ELIGIBLE SPOUSE/PRIMARY DEPENDENT)
SINGLE/FAMILY RATES	FAMILY RATE	SINGLE/FAMILY RATES
$150/$300	$200	$50/$100

NOTE: If your Last Day Worked or UPS Termination Date is after the 1st day of the month, your first payment will be prorated from your termination date to the end of the month and full monthly payments will be required beginning with the 1st full month of retiree coverage. The Trust Office will ask for that prorated payment based on your final termination date as confirmed on your retiree application and/or with UPS. The Trust Office will bill you for the 1st month's prorated payment upon approval of your application.

To avoid termination of your medical coverage, the monthly self-payment must be received no later than the 15th day of the month prior to the month in which coverage is desired. It will be your responsibility to make sure your monthly payment is received timely. To learn more about direct payment, please visit www.wr177healthcare.com and print a direct payment authorization form today!

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Retiree Medical Plan Application/Deferral Form

(For Participants who Retire on or after January 1, 2014)

IMPORTANT - DO NOT DELAY. Before benefits for you and your family can be paid, this form must be sent to the Fund Office – **fully completed, signed and dated by you.** Without this information, the Fund Office **cannot certify benefits** to health care providers. Send your completed form and required attachments to the fund office now.

Please Print Clearly Using Heavy Dark Ink:

1. Name _____
   First Middle Last
2. S.S. #_____ 3. Phone # ( )_____
4. Address _____
   City State Zip
5. Date of Birth_____ 6. Married: Yes ☐ No ☐
7. What was your **last day worked**? _____ 8. Local Union No. _____
9. What is your **termination date with UPS** and/or **What is your Last Paid Date with UPS?** _____
10. Have you applied for **pension benefits**? Please answer below:

10A. Yes ☐ If yes, what is your **Pension Effective Date** _____ *

You must attach a copy of your Pension Award/Application/Confirmation documents. Failure to include those items will delay your retiree application processing!

10B. No ☐ If you have not applied for your pension benefits, your retiree application cannot be approved. Please provide an explanation of your pension award status below:

_____

11. Are you eligible for a **Social Security Disability**? Yes ☐ No ☐
    If yes, attach a copy of your Social Security Award Letter with this application

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12. ARE YOU ELIGIBLE FOR **MEDICARE BENEFITS**? YES ☐ NO ☐
IF YES, ATTACH A COPY OF YOUR MEDICARE CARD WITH THIS APPLICATION

13. IF YES, ARE YOU ENROLLED IN **MEDICARE BOTH PARTS A & B**? * YES ☐ NO ☐

***BECAUSE THIS PLAN IS DESIGNED TO WORK WITH MEDICARE PARTS A AND B, IT IS CRITICALLY IMPORTANT THAT YOU ENROLL IN MEDICARE PARTS A AND B WHEN YOU ARE ELIGIBLE TO DO SO!!! OTHERWISE, YOU WILL NOT RECEIVE THE FULL BENEFITS TO WHICH YOU ARE ENTITLED UNDER THIS PLAN.**

14. **LIST ALL ELIGIBLE DEPENDENTS** (IF ANY):

FULL NAME	SSN	RELATIONSHIP	DATE OF BIRTH	MEDICARE ELIGIBLE
				YES / NO
				YES / NO

IF YOU HAVE ADDITIONAL DEPENDENTS, PLEASE LIST THEM ON A SEPARATE PAGE.

15. **ONE TIME VOLUNTARY DEFERRAL OPTION**: You and/or your spouse are eligible to defer your enrollment in this Retiree Plan at any time on a one-time basis **with proof of other health coverage**. You must still elect Retiree coverage within 60 days of retirement; if you want to use the one-time, voluntary deferral option, you can do so by checking this box and providing proof of other health coverage along with the effective date of other health coverage.

☐ **I elect to defer my enrollment until a future month.**

☐ **My spouse has elected to defer enrollment until a future month.**

(Proof of Other Health Insurance coverage must be provided to facilitate this One-time deferral and must also be provided at time of Re-enrollment to show there was continuous health insurance coverage)

FRAUD NOTICE

I UNDERSTAND THAT THE TRUST FUND IS RELYING ON MY ANSWERS ON THIS FORM. I REPRESENT, UNDER PENALTY OF PERJURY, THAT THE ANSWERS GIVEN TO ALL QUESTIONS ON THIS FORM ARE TRUE AND ACCURATE. I UNDERSTAND THAT IF I KNOWINGLY AND WITH INTENT TO DEFRAUD THE TRUST FUND, PROVIDE FALSE INFORMATION OR CONCEAL, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, I MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES. I UNDERSTAND THAT IT IS A FEDERAL CRIME, PUNISHABLE BY FINE OR IMPRISONMENT, OR BOTH, TO KNOWINGLY MAKE FALSE STATEMENTS ON THIS VERIFICATION FORM.

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I HEREBY AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CLAIM. I WILL REIMBURSE THE FUND FOR ANY OVERPAYMENT MADE TO ME OR IN MY BEHALF DUE TO ERROR ON THIS FORM. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR HIS SERVICES AS DESCRIBED HEREON OR IN SUPPLEMENTAL STATEMENTS, NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN FORCE UNTIL CANCELLED IN WRITING BY ME.

16. **ELECTION OF RETIREE PLAN COVERAGE**: I HEREBY ELECT TO ENROLL IN THE **TEAMSTERS WESTERN REGION & LOCAL 177 RETIREE HEALTH CARE PLAN** AND MY INITIAL PAYMENT OF $_____ IS ENCLOSED. PAY BY PERSONAL CHECKS, MONEY ORDERS OR CASHIER'S CHECKS ONLY; **CASH IS NOT ALLOWED**.
(IF YOU ARE DEFERRING ENROLLMENT, PAYMENT WILL BE DUE AT THE TIME YOU RE-ENTER THE PLAN).

MAKE CHECK PAYABLE TO: **TWR & LOCAL 177 RETIREE HEALTH PLAN**
P.O. BOX 43110 PHOENIX, AZ 85080-3110

I HAVE READ THE FRAUD NOTICE ABOVE ALONG WITH THE ELIGIBILITY RULES & INSTRUCTION GUIDE. I UNDERSTAND THE IMPORTANCE OF TIMELY PAYMENTS AND I ALSO UNDERSTAND THAT THE BOARD OF TRUSTEES MAY BE REQUIRED TO ADJUST THE MONTHLY CONTRIBUTION RATE.

SIGNATURE_____ DATE_____

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RETIREE CHANGE FORM

✓ **CHECK ONE:** ☐ **REMOVE DEPENDENT** ☐ **ADD CHILD** ☐ **CHANGE PERSONAL DATA**

RETIREE INFORMATION

LAST NAME:	FIRST NAME:	MI:	☐ M ☐ F	BIRTH DATE / /
ADDRESS CITY STATE ZIP				PHONE NO. ( ) -
SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed			LOCAL UNION NO.
MEDICARE ELIGIBLE? **IF MEDICARE ELIGIBLE ATTACH A COPY OF YOUR MEDICARE CARD** ☐ Yes ☐ No				

REMOVE SPOUSE – *YOU MUST ATTACH A COPY OF YOUR QUALIFYING EVENT LEGAL DOCUMENT SUCH AS A DIVORCE DECREE OR DEATH CERTIFICATE*

SPOUSE LAST NAME:	SPOUSE FIRST NAME:	MI:	BIRTH DATE: / /	☐ M ☐ F	SOCIAL SECURITY NO.

ADD CHILDREN - IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST,FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)

REMOVE CHILDREN - IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST,FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)

(Continued on Reverse Side)

ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES. PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION FOR A FULL EXPLANATION.

✓ ***TO ADD CHILDREN, YOU MUST ATTACH A COPY OF THE CERTIFIED BIRTH CERTIFICATE***

✓ ***SOCIAL SECURITY NUMBERS ARE REQUIRED FOR ALL DEPENDENTS.***

✓ ***COVERAGE FOR A DEPENDENT CHILD TERMINATES AT AGE 19. COVERAGE CAN BE CONTINUED UNTIL AGE 25, PROVIDED THE DEPENDENT IS ATTENDING COLLEGE OR AN ACCREDITED SCHOOL AS A FULL TIME STUDENT. THE FULL TIME STUDENT STATUS FORM CAN BE FOUND ON THE WEBSITE AT WWW.WR177HEALTHCARE.COM.***

****NOTE – THE ABOVE INFORMATION WILL BE NECESSARY EACH SEMESTER IN ORDER TO CONTINUE COVERAGE.****

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✓ _____ _____

RETIREE SIGNATURE DATE