PHOENIX, AZ SERVICE CENTER
2550 West Union Hills, Suite 250
Phoenix, AZ 85027

SALT LAKE CITY, UT SERVICE CENTER
5251 Green Street., Suite 200
Murray, UT 84123

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RETIREE MEDICAL PLAN APPLICATION FORM

Please complete this application and forward it to the administrative office within 120 days of your retirement date. The initial eligibility date will be the same as the retirement effective date, providing you meet all eligibility requirements. An application submitted more than 120 days will not be accepted and neither the Retiree, nor his or her Dependents, nor his or her survivors will be eligible to participate in the Retirees' Plan.

1) PARTICIPANT INFORMATION

LAST NAME:	FIRST NAME:	MI:	GENDER:
			☐ M ☐ F

BIRTH DATE:	SOCIAL SECURITY NO. *	PHONE NO.
/ /	/ /	( ) -

ADDRESS	CITY	STATE	ZIP

MARITAL STATUS:	LOCAL UNION NO.
☐ Married ☐ Divorced ☐ Single ☐ Widowed	

WHAT WAS YOUR LAST DAY WORKED?	WHAT IS YOUR TERMINATION DATE?	LIST THE COMPANIES YOU WORKED FOR WHILE COVERED UNDER THE UT-ID TEAMSTERS
/ /	/ /	

HAVE YOU APPLIED FOR PENSION BENEFITS?

☐ YES **IF YES, WHAT IS YOUR PENSION EFFECTIVE DATE?** / /

☐ 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:**

____

ARE YOU ELIGIBLE FOR A SOCIAL SECURITY DISABILITY?

☐ YES ☐ NO **IF YES, ATTACH A COPY OF YOUR SOCIAL SECURITY AWARD LETTER WITH THIS APPLICATION.**

ARE YOU ELIGIBLE FOR MEDICARE BENEFITS?	IF YES, ARE YOU ENROLLED IN MEDICARE BOTH PARTS A & B?
☐ YES ☐ NO **IF YES, ATTACH A COPY OF YOUR MEDICARE CARD WITH THIS APPLICATION.**	☐ 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.**

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 REGULATION ADOPTED BY THE BOARD OF TRUSTEES. PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION FOR A FULL EXPLANATION.

2) SPOUSE INFORMATION

LAST NAME:	FIRST NAME:	MI:	GENDER:
			☐ M ☐ F

BIRTH DATE:	SOCIAL SECURITY NO. *	PHONE NO.
/ /	/ /	( ) -

ARE YOU ELIGIBLE FOR MEDICARE BENEFITS?	IF YES, ARE YOU ENROLLED IN MEDICARE BOTH PARTS A & B?
☐YES ☐ NO IF YES, ATTACH A COPY OF YOUR MEDICARE CARD WITH THIS APPLICATION.	☐YES ☐ NO

3) LIST ALL ELIGIBLE DEPENDENTS (IF ANY) - IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY NO. *	RELATIONSHIP	MEDICARE ELIGIBLE
	☐M ☐F				☐YES ☐NO
	☐M ☐F				☐YES ☐NO
	☐M ☐F				☐YES ☐NO
	☐M ☐F				☐YES ☐NO

4) VOLUNTARY DEFERRAL OR SUSPEND OPTION:

YOU AND/OR YOUR SPOUSE ARE ELIGIBLE TO DEFER OR SUSPEND YOUR ENROLLMENT IN THIS RETIREE PLAN AT ANY TIME WITH PROOF OF OTHER HEALTH COVERAGE. YOU MUST STILL ELECT RETIREE COVERAGE WITHIN 120 DAYS OF RETIREMENT; IF YOU WANT TO USE THE VOLUNTARY DEFERRAL OR SUSPENSION 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 or suspend my enrollment until a future month.**

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

(Proof of Medical and Drug Coverage must be provided to facilitate this deferral or suspension and must also be provided at time of Re-enrollment to show there was continuous health insurance coverage)

I hereby make application for Retiree coverage under the **Utah-Idaho Teamsters Retirees' Trust** for myself and my eligible dependents and certify that the above information is correct.

My last date of employment was ____

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.

EMPLOYEE SIGNATURE	SOCIAL SECURITY NUMBER	DATE