**WESTERN TEAMSTERS WELFARE TRUST**
c/o Northwest Administrators, Inc. | 225 South Lake Avenue, Suite 1200, Pasadena, CA 91101 | (800) 872-5439 | Fax: (626) 463-6048

You must complete this application and forward it to the Administrative Office either prior to your retirement date or no later than **90 days** following your retirement date or exhaustion of COBRA coverage under an active health plan. **An application submitted later than 90 days following your retirement date or exhaustion of COBRA coverage will not be approved, therefore, you and your dependents will not qualify for coverage**. You will be required to make monthly self-payments for yourself and your spouse (**if coverage is elected for your spouse**). There are, however, some exceptions to the above requirements if you retire because of total disability. The Administrative Office will notify you of the applicable self-payment rates upon receipt of your application. Please review the Plan booklet in its entirety as the provisions therein govern your rights and obligations under the Western Teamsters Welfare Trust.

***PLEASE DETACH APPLICATION HERE***

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## WESTERN TEAMSTERS WELFARE TRUST – APPLICATION FOR RETIREE PLAN COVERAGE

| | | | | |
|---|---|---|---|---|
| Social Security Number: | Participant Name: (Last) (First) (MI) | | | |
| Phone Number:<br>( ) | Street (or RFD No.) Address: (City) (State) (Zip) | | | |
| Date of Birth: | Date of Retirement: | Last Day of Active Employment: | Will Receive:<br>Regular Pension Benefit: ☐<br>Disability Pension Benefit: ☐ | Local Union No.: |
| Are you currently disabled?<br>Yes ☐ No ☐<br>***If you are awarded Social Security Disability, please send a copy of the Award Letter to above address.*** | If yes, list dates of disability: | Have you been awarded Social Security Disability benefits?<br>Yes ☐ No ☐ | Social Security Disability effective date: | |
| Are you married?<br>Yes ☐ No ☐ | Do you wish coverage for your Spouse? Yes ☐ No ☐<br>Spouse's Name: _____<br>***(If your spouse has other Group Insurance as a result of employment you can request a postponement of spousal coverage. See reverse side for details on how to apply.)*** | | | |
| Spouse's Social Security Number: | | | | |
| Spouse's Date of Birth: | Name and Address of Spouse's Employer, if applicable: | | | |

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|---|---|
| Do you wish to receive an application to postpone your Retirees health coverage for either yourself or your spouse?<br>Yes ☐ No ☐<br>If Yes, who are you requesting coverage to be postponed for**:**<br>☐ **Self** ☐ **Spouse Only** ☐ **Joint Postponement**<br>***(See the back of this application for information on Postponement of Retirees Health Coverage.)*** | Do you have Medicare Part A coverage? Yes ☐ No ☐<br>Effective date: _____<br>Do you have Medicare Part B coverage? Yes ☐ No ☐<br>Effective date: _____<br>Enter Your Medicare ID (MBI) Number: _____<br>Does your Spouse have Medicare Part A coverage? Yes ☐ No ☐<br>Effective date: _____<br>Does your Spouse have Medicare Part B coverage? Yes ☐ No ☐<br>Effective date: _____<br>Enter Your Spouse's Medicare ID (MBI) Number: _____<br>***If yes to any of the above, please attach a copy of Medicare Card or Social Security Disability Award Letter(s).*** |
| List Dependent Children:<br>Name _____ DOB _____<br>Name _____ DOB _____<br>Name _____ DOB _____ | |

**LIST THE EMPLOYER(S) FOR WHOM YOU HAVE WORKED DURING THE PAST SEVEN YEARS**

Begin with last employer. If working as a casual during the time period, indicate dates of casual employment. This information is required to determine if you met the requirements for eligibility. (If additional space is needed, please attach a separate sheet of paper.)

| EMPLOYER | FROM | TO |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |

**CERTIFICATION OF INFORMATION**

**Application is hereby made for coverage under the Western Teamsters Welfare Trust for myself and spouse (if elected). I hereby certify that the above information is correct. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information, to release any and all information pertaining to the care or benefits provided to me or my Spouse. I also understand that if my last contributing employer, as defined by the plan, ceases participation under the Western Teamsters Welfare Trust for any reason subsequent to my retirement, I (We) may be required to pay an additional premium to continue coverage.**

**YOUR FULL SIGNATURE** _____ **DATE** _____

**SPOUSE'S FULL SIGNATURE** _____ **DATE** _____

## WESTERN TEAMSTERS WELFARE TRUST – IMPORTANT INFORMATION, PLEASE READ

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|---|---|
| **Postponement of Retirees Coverage:** | Western Teamsters Welfare Trust allows retirees and spouses to postpone the commencement of their Retirees Plan coverage while they have other employment-related group health coverage. To request a postponement of your retiree's health coverage for either yourself or your spouse, a Request to Suspend or Postpone Retirees Coverage application must be completed and approved by your Area Administrative Office. **Please note, your spouse cannot continue participating in the Retirees Plan if you, as the Retiree, suspend your coverage.** Contact the Administrative Office if you wish to postpone coverage. |
| **Monthly Self-Payments:** | A monthly self-payment is required for eligible Retirees and dependent spouses (if applicable) to maintain coverage. The amount differs depending on whether the Retiree and/or spouse are eligible for Medicare. Upon approval of your application, you will receive a list of the applicable self-payment rates. Retirees (and their spouses) utilize Electronic Funds Transfer (EFT) to make their self-payments. Failure to make any required self-payments will result in permanent termination of Retiree benefits**.** |
| **Disability:** | If you are disabled, it is possible that the monthly self-payment may be waived during the period that you are waiting for Medicare, provided that you have a Social Security disability award. A copy of the award letter is required before this can be determined. |
| **Address Change:** | Please notify your Area Administrative Office of any future change of address. |
| **Marital Status:** | Please notify your Area Administrative Office of any change in your marital status. |
| **Deferral of Coverage Until Medicare Eligible:** | If you or your spouse became eligible to participate in the Retiree Plan on or after September 1, 2002, you can make a one-time election that defers Retiree Plan participation until you are Medicare eligible. Under this option, there is no requirement that you or your spouse have other health coverage while you are not participating in the Retiree Plan until you are Medicare eligible. To select this option, you must submit a deferral request to the Trust Administrative Office within the same 90 day period you have for electing to initially participate in the Retiree Plan. You must then notify the Trust Administrative Office within 30 days of your becoming Medicare eligible. |

### ADMINISTRATIVE USE ONLY

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1___ | 1___ | 1___ | 1___ | 1___ | 1___ | 1___ | 1___ | 1___ | 1___ |
| 2___ | 2___ | 2___ | 2___ | 2___ | 2___ | 2___ | 2___ | 2___ | 2___ |
| 3___ | 3___ | 3___ | 3___ | 3___ | 3___ | 3___ | 3___ | 3___ | 3___ |
| 4___ | 4___ | 4___ | 4___ | 4___ | 4___ | 4___ | 4___ | 4___ | 4___ |
| 5___ | 5___ | 5___ | 5___ | 5___ | 5___ | 5___ | 5___ | 5___ | 5___ |
| 6___ | 6___ | 6___ | 6___ | 6___ | 6___ | 6___ | 6___ | 6___ | 6___ |
| 7___ | 7___ | 7___ | 7___ | 7___ | 7___ | 7___ | 7___ | 7___ | 7___ |
| 8___ | 8___ | 8___ | 8___ | 8___ | 8___ | 8___ | 8___ | 8___ | 8___ |
| 9___ | 9___ | 9___ | 9___ | 9___ | 9___ | 9___ | 9___ | 9___ | 9___ |
| 10___ | 10___ | 10___ | 10___ | 10___ | 10___ | 10___ | 10___ | 10___ | 10___ |
| 11___ | 11___ | 11___ | 11___ | 11___ | 11___ | 11___ | 11___ | 11___ | 11___ |
| 12___ | 12___ | 12___ | 12___ | 12___ | 12___ | 12___ | 12___ | 12___ | 12___ |
| TL | TL | TL | TL | TL | TL | TL | TL | TL | TL |

**ELIGIBILITY RESULTS**

_____ / _____ **Months**

### ADMINISTRATIVE USE ONLY

Elig. Req. _____ /

Pens. Eff. Date: _____

Carrier: _____

Eff. Date: _____

Log No: _____

Initial Billing: _____