MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

RETIREE PROGRAM ENROLLMENT FORM
LOCAL UNIONS: 219-275-445-498-557-665-692-948-979-1070

Under the Plan's eligibility rules, you must apply for participation in the Program while you are still eligible for the regular active employee benefits or COBRA in the Health Plan. If you are eligible under another health benefit program when you retire, including a plan at your spouse's employer, and you fail to take this coverage now, you will not be given another opportunity to enroll in the Program when the other coverage stops.

PLEASE CHECK EITHER BOX A OR B AND COMPLETE ALL OF THE APPLICABLE INFORMATION BELOW:

☐ A. I have read this form and I forever waive my right to enroll in the Retiree Healthcare Program.

Name: _____ MID or SS #: _____

Signature: _____

☐ B. I hereby apply for participation in the Retiree Program being sponsored by the Plan and certify that:

1. I am a retired member currently receiving either monthly pension benefits from an industry sponsored pension plan or monthly disability benefits from Social Security.

2. I have been eligible for regular or COBRA coverage under the Health Plan in which my Local Union has been participating at least 36 of the last 60 months prior to my retirement date.

3. The information set forth below is accurate to the best of my belief and knowledge.

4. I understand that my participation in the Retiree Program is conditioned on these facts. I wish participation for:

(check appropriate boxes)

☐ MYSELF - Name: _____

Date of Birth: _____

Retirement Date: _____

Disability Date (if applicable): _____

☐ SPOUSE - First Name/Middle Initial: _____

Date of Birth: _____

SS #: _____

Medicare Date (Part A & B): _____
(if applicable)

☐ DEPENDENT - First Name/Middle Initial: _____

Date of Birth: _____

SS #: _____

Managed for the Trustees by: Wilson-McShane Corporation
3001 Metro Dr. Suite 500 • Bloomington, MN 55425
Toll-Free (855) 633-4584 • FAX (952) 854-1632
www.michiganelectrical.org

YOU HAVE (4) OPTIONS FOR REMITTING PAYMENTS FOR THE RETIREE PLAN:

Option 1: You may remit a check each month to the Health Plan and may pay up to six months in advance. If you choose this option, please include your first payment with this Enrollment form by the 15th of the month. Make checks payable to: MEEHP
Option 2: You may elect to have your payments deducted from your Pension check each month (complete section 1 on the reverse side of this form)
Option 3: You may elect to have your payment deducted from your Special Fund account each month (complete section 2 on the reverse side of this form)
Option 4: You may elect to have your payment deducted from your Special Fund until it's exhausted and then have it deducted from your Pension check. If you elect this option, please complete both sections on the reverse side.

I understand that the coverage provided under the Retiree Program is a subsidized coverage and that the Trustees may take action to reduce the coverage, change the monthly payment or eliminate the coverage if the Trustees determine the subsidy amount is too great a portion of Plan costs.

C. NAME (PRINTED): _____ SS #: _____

SIGNATURE: _____ LOCAL UNION #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ DATE: _____

PENSION CHECK DEDUCTION AUTHORIZATION (Section 1)

I, the undersigned, am receiving a monthly benefit from my Pension Fund _____

And I am also maintaining my eligibility for benefits under the Michigan Electrical Employees' Health Plan by means of self-payments for the RETIREE PLAN.

As a convenience to me, I hereby request and authorize you to deduct from my monthly Pension Fund benefit whatever amounts may be required from time to time to maintain HEALTH coverage for myself and my spouse (if applicable) in the RETIREE PLAN (or Spouse Plan) as reported to you by the Health Plan and/or coverage in the SUPPLEMENT TO MEDICARE PLAN, as reported to you by the Health Plan, and to remit such deducted amounts directly to the Health Plan.

I understand that I may revoke this authorization at any time by written notice to the Health Plan at 3001 Metro Dr. Suite 500, Bloomington, MN 55425, but also understand that at least 60 days advance notice to do so is required.

_____ _____

NAME (Print or Type) SIGNATURE

_____ _____

SS # DATE

EXPLANATION

This Assignment and Authorization Request Form is designed to serve as a convenience to you. Authorizing deductions of self-payments from monthly Pension benefits, while purely voluntary, will eliminate the inconvenience and expense of writing and mailing checks or money orders to the Health Plan Office each month. More importantly, this will eliminate the risk of losing coverage due to illness, travel, delay in the mail, or other circumstances which would prevent you from remitting your self-payment within the prescribed time. The amount deducted cannot, of course, be more than your monthly benefit from the Pension Fund.

If there are any changes in the rate for your self-payment, you will be notified in advance and will be able to revoke your authorization for deductions if you choose to end coverage under the Health Plan.

The first deduction from your Pension check will be one month prior to your termination date from the Active Plan. (EXAMPLE: If you terminate the Active Plan on June 1, your May 1 Pension check will have the payment for the month of June deducted from it. This enables the Plan Office to receive the payment from the Pension Fund and process the payment in the Health Plan to give you eligibility.)

SPECIAL FUND DEDUCTION AUTHORIZATION (Section 2)

I hereby authorize the Health Plan to deduct from my Special Fund the amount required each month to maintain eligibility in the Retiree Program or the Supplement to Medicare Plan, as well as the Spouse Plan for my Spouse, until the Special Fund balance is reduced to less than the amount required for a full payment.

_____ _____

NAME (Print or Type) SIGNATURE

_____ _____

SS # DATE