MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

WIDOW ENROLLMENT FORM

Please complete the following information:

YOUR NAME:____________________________________ WIDOW OF: ____

SS#____ SS#____

ADDRESS: _______________________________________ DATE DECEASED:_______________________________________

_______________________________________ LOCAL UNION #: _______________________________________

PHONE #: ____ YOUR DATE OF BIRTH: _________________________________

DEPENDENT CHILDREN:

NAME: ____ BIRTH DATE: _________________ SSN: ____________________

NAME: ____ BIRTH DATE: _________________ SSN: ____________________

NAME: ____ BIRTH DATE: _________________ SSN: ____________________

You may continue in the WIDOW PLAN until you reach the age of 65 or eligible for Medicare or if you remarry.
RATE: **$290/MONTH** (Subject to change with contribution rate increases)

You may continue in the SUPPLEMENT TO MEDICARE PLAN (must have Medicare Part A and B) until you remarry.
RATE: $__________/MONTH (Subject to change with contribution rate increases)

YOU HAVE THREE OPTIONS FOR REMITTING PAYMENTS:

Option 1: You may remit a check each month to the Health Plan and you may pay up to (6) months in advance. If you choose this option, please include your first payment with this enrollment form. Make checks payable to:
Michigan Electrical Employees Health Plan or MEEHP
Option 2: You may elect to have your payment deducted from your husband's Special Fund account until the account is exhausted.
Option 3: You may elect to have your payment deducted from your husband's Pension check.

Widow's Signature ______________________________________

Date____

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SPECIAL FUND DEDUCTION AUTHORIZATION

I HEARBY AUTHORIZE THE HEALTH PLAN TO DEDUCT FROM MY HUSBAND'S SPECIAL FUND ACCOUNT THE AMOUNT REQUIRED EACH MONTH TO MAINTAIN ELIGIBILITY IN THE WIDOW PLAN OR THE SUPPLEMENT TO MEDICARE PLAN UNTIL HIS SPECIAL FUND BALANCE IS EXHAUSTED.

____________________________________ ____ _________________
NAME (Print or type) WIDOW'S SIGNATURE DATE

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PENSION DEDUCTION AUTHORIZATION—See enclosed form.
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