Ohio Carpenters Health Fund

33 Fitch Blvd
Austintown, Ohio 44515

1-800-435-2388

To: Retirees of the Health and Welfare Fund

COVERAGE ELECTION FORM

Please select one of the coverage classes listed below:

Classification	Check Only One	Single Coverage	Check Only One	Family Coverage
Pre-Medicare Coverage with Dependents	_____	$ 809.00	_____	$ 1,145.00
All persons eligible to participate in Medicare **must** obtain both Medicare Part A and Part B				
Single Coverage with Medicare	_____	$ 317.00		
One person with Medicare & one person without Medicare			_____	$ 1,145.00
Two people with Medicare			_____	$ 635.00

All rates are monthly amounts. These rates and provisions of the Plan are subject to change upon approval of the Board of Trustees.

If you wish to change your coverage by dropping your spouse and all dependents, please indicate by checking here: _____.

I have other insurance from my spouse, coverage through _____ (carrier). Upon expiration of this coverage, I will have 60 days to contact the Fund Office and re-enroll in Ohio Carpenters Health Fund.

If you do not want to continue your coverage in the Plan, please indicate by checking here:_____.
Once coverage is terminated, you cannot be reinstated for any reason.

If you are married or have dependents that are covered and you elect to have the single coverage, your spouse and/or dependents will not be allowed to rejoin the Plan at a later date. Both the member and the spouse must sign the form.

_____ _____ _____
Member Name Date Spouse Name (Please Print)

_____ _____ _____ _____
Member S/N Date of Birth Spouse S/N Date of Birth

_____ (___)_____
Member Address Telephone Number

_____ _____
City, State & Zip Code Date of Retirement

$_____
Dollar Bank Balance