IBEW Local 347 Electrical Workers Health and Welfare Fund

PO Box 26068
Salt Lake City, UT 84126-0068

CompuSys of Utah, Inc.

Toll Free (844) 347-IBEW (4239)
Fax (801)975-1342

RETIREE COVERAGE APPLICATION

If you would like to obtain Retiree coverage from the Plan, you must complete this Retiree Coverage Application ("Application") at the time you notify the Fund Office of your retirement or Total and Permanent Disability (as applicable). Many of the elections on this Application are irrevocable. This means it is extremely important that you carefully read this entire Application before you fill it out and submit it to the Fund Office. If you have any questions regarding this Application please contact the Fund Office.

Effective_____, I request my Health & Welfare coverage be changed to Retiree coverage. I understand this changes my benefits and my premium amounts (Complete boxed section and see Retiree Benefit Explanation below).

Complete the boxed section below, read Retiree Benefit Explanation section, sign and return to the Fund Office.

To implement the change to Retiree coverage, please provide the necessary information:

Covered Employee's Name: _____

Covered Employee's SSN: _____

Covered Employee's Date of Birth: _____

Other Insurance: (Please Circle) Y N Carrier: _____

If you are a Retiree and you elect coverage under this Plan, you may also elect coverage for your Dependents. An additional premium amount may apply to coverage of Dependents of Retirees. A Retiree may not select coverage for his Dependents if he declines Retiree coverage for himself. Once a Retiree has declined Retiree coverage, he may not later seek to enroll himself or his Dependents.

If you are a Retiree and you elect coverage for yourself, but decline coverage for your Dependents, you may not subsequently obtain coverage for any Dependents who could have been enrolled at the time of your retirement. A Retiree's Dependents are not entitled to receive any benefits from this Plan unless the Retiree makes an affirmative election at the time that he provides the Fund Office with a form requesting Retiree health coverage, or during a special enrollment period with respect to that Dependent.

A special enrollment period is provided with respect to a Dependent of a Retiree under the following circumstances:

(a) Newly Acquired Dependents:
If a person becomes a Dependent of a covered Retiree through marriage, birth, adoption, placement for adoption or a court order (including a QMCSO) that Dependent will be entitled to a 90 day special enrollment period beginning on the date of marriage, birth, adoption, placement for adoption or date a court order is entered. This means that if the Dependent's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of the marriage, birth, adoption placement for adoption or date a court order is entered, the Dependent will be covered effective 12:01 a.m. on the date of the marriage, birth, adoption, placement for adoption or effective date of the court order. If the Dependent's enrollment form is not postmarked or otherwise positively received by the Fund Office within 90 days of the marriage, birth, adoption, placement for adoption or the date a court order is entered the Retiree may not subsequently obtain coverage for the Dependent.

(b) Spouse who has other Coverage:
If the spouse of a Retiree has coverage under an employer-sponsored health plan, and the Retiree declines coverage under this Plan for his spouse because of the other coverage, the spouse will be entitled to a 90 day special enrollment period beginning on the date that the spouse loses such other coverage or any replacement coverage provided the following requirements are met:

(1) The Retiree or spouse must provide the Plan Administrator with proof of other coverage (for example a certificate of creditable coverage) upon declining this Plan's coverage, along with notice that she is declining coverage under this Plan because of the other coverage; and

(2) The spouse's enrollment form must be postmarked or otherwise positively received by the Fund Office within 90 days of losing such other coverage or replacement coverage. If the spouse's enrollment form is postmarked or otherwise positively received by the Fund Office within 90 days of losing such other coverage, the spouse will be covered effective 12:01 a.m. on the date her other coverage was terminated.

A spouse using other coverage will not be treated as having a lapse in coverage by reason of the other coverage.

I do want_____do not want_____to extend my benefits to cover my Dependents. If I do want to cover my Dependents, here is the necessary information:

Dependent's Name	Relationship	Date of Birth	Social Security Number	Other Insurance	Other Insurance Carrier
				Y N	
				Y N	
				Y N	
				Y N	
				Y N	

Retiree Benefit Explanation

When you become a Retiree, you may elect to receive either Plan A Coverage or Plan B Coverage. If y o u are a Retiree and you elect Plan A Coverage, you may elect to change to Plan B Coverage. The change from Plan A Coverage to Plan B Coverage will be effective the first day of the month following the month that the Fund Office receives your Retiree Plan B Notification. Once you elect Plan B Coverage, you may not subsequently elect Plan A Coverage.

Plan A Coverage and Plan B Coverage are defined as follows **(please circle your plan choice)**:

(a) Plan A Coverage

Plan A Coverage is identical to the coverage provided under the Plan to Covered Employees, except that it does not include Short-Term Disability Benefits. The Retiree Premium for a Retiree and at least one Dependent will equal the Monthly Premium *(i.e.* the amount paid by a Covered Employee). The Retiree Premium for a Retiree without any Dependents will equal 50% of the Monthly Premium (i.e. 50% of the amount paid by a Covered Employee).

(b) Plan B Coverage

Plan B Coverage is identical to the coverage provided under the Plan to Covered Employees, except that it does not include Short-Term Disability Benefits, Dental Benefits or Maternity Services. The Retiree Premium for a Retiree and at least one Dependent will equal 80% of the Monthly Premium (i.e. 80% of the amount paid by a Covered Employee). The Retiree Premium for a Retiree without any Dependents will equal 40% of the Monthly Premium (i.e. 40% of the amount paid by a Covered Employee).

If you are a Disabled Retiree who became eligible for Retiree coverage and you are still Totally and Permanently Disabled when you attain 55 years of age, then effective 12:01 a.m. on the first day of the month following your 55th birthday, the terms of your eligibility and coverage will become identical to those in place for a Participant who became eligible for Retiree coverage.

In other words, starting the first day of the month following your 55th birthday, you will no longer be asked periodically to submit proof that you are still Totally and Permanently Disabled, you will no longer be required to notify the Plan Administrator if you recover from your Total and Permanent Disability and you will not lose Retiree coverage if you recover from your Total and Permanent Disability.

You may choose to drop coverage for yourself or Dependents at any time. If you choose to cancel all coverage, I understand that my decision is irrevocable.

I am also stating through my signature below, that I am not currently working in Covered Employment, in employment or self-employment in the electrical industry for an employer who does not have an obligation to contribute to this Plan, or in employment or self-employment in a non-bargaining position for an Employer; and that I intend to permanently cease working in Covered Employment, in employment or self-employment in the electrical industry for an employer who does not have an obligation to contribute to this Plan, and in employment or self-employment in a non-bargaining position for an Employer.

_____
Signature

_____
Date

Retiree Plan B Notification

Effective_____, I_____, am choosing to participate in the Local 347 Electrical Workers Health and Welfare Fund as a Retiree under Plan B coverage. I understand that participating under Plan B excludes me, and any of my Dependents, from dental coverage and maternity benefits, as well as Short Term Disability.

_____
Signature

_____
Date