RETIREE'S WELFARE TRUST
2323 EASTLAKE AVE E., SEATTLE WA 98102 • PHONE (206) 329-4900 • FAX (206) 726-3209

APPLICATION FOR COVERAGE – IMPORTANT INFORMATION
PLEASE KEEP WITH YOUR PLAN DOCUMENTS

The Retiree's Welfare Trust (RWT) is a collectively bargained benefit which provides access to medical and prescription coverage at retirement, if you meet the eligibility requirements. Only employees that have received contributions from a participating Covered Employer are potentially eligible for Retiree's Welfare Trust medical and prescription coverage (Retiree's coverage) after retiring.

To qualify for Retiree's coverage when you retire from Teamster Covered Employment you must:

1. Be at least 50 years of age (or, if younger, eligible for a PEER pension under the Western Conference of Teamsters Pension Plan).
2. Have employer contributions to the Trust for at least 30 months out of the 48 consecutive months immediately preceding retirement. For Plus XL Plan eligibility, a minimum of 6 months (of the 30 months) must be at the Plus XL employer contribution rate (if your Plus XL employer contributions begin before December 31, 2023); or, if Plus XL contributions begin after December 31, 2023, 30 months of RWT Plus XL Plan contributions are required to qualify for RWT Plus XL.
3. File an application for benefits within 180 days of your retirement date or within 60 days after COBRA or any Other health insurance plan ends.

Note: Failure to apply may result in the permanent loss of these benefits. **If you have Other coverage at the time of your retirement, you must still apply for RWT and then Suspend (Postpone) coverage while you have Other health insurance until such time as the Other coverage terminates.** You must have continuous coverage.

Applications for Coverage may be submitted to the Administrative Office up to 6 months in advance of your retirement date. Once approved, to activate your coverage you must also make required monthly self-payments (premium payments) via automatic deduction from your bank account.

Please review the Application for Coverage – Important Information on the next page and contact the Trust Administrative office at (800) 692-5179 if you have further questions.

You must notify the Administrative Office immediately if you or your spouse/dependent(s) obtain Other Health Insurance or become eligible for Medicare, for any reason.

RETIREE'S WELFARE TRUST - APPLICATION FOR COVERAGE – IMPORTANT INFORMATION
PLEASE READ AND KEEP WITH YOUR PLAN DOCUMENTS

Application for Coverage Provisions:	You must send this completed application to the Administrative Office within 180 days of your retirement from Covered Employment or 60 days after you are no longer covered under any other health insurance plan including COBRA, whichever is later. Applications submitted after these deadlines will not be approved and you and your dependents will not qualify for coverage. If you meet the Trust's eligibility requirements, your Retiree's Welfare Trust coverage (Retiree's coverage) will be effective immediately after your other coverage ends including any COBRA extensions of that coverage. You will be required to make monthly self-payments (premiums) if you qualify for coverage effective from the date other coverage ends. There may be an exception to this requirement if you retire prior to age 50 because of total disability. Please review the Plan booklet in its entirety as the provisions therein govern your rights and obligations under the Plan.
Retirement/Covered Employment Defn:	The word "retirement" or "retired" means the complete and permanent cessation of covered employment. "Covered Employment" means employment under a collective bargaining or written agreement requiring employer contributions to the Retiree's Welfare Trust.
Suspension of Coverage:	Retirees **must** Suspend (postpone) their Retiree's coverage at the time of retirement if they have other health insurance including COBRA. However, Retirees **must** still apply for coverage within 180 days of retirement from covered employment or 60 days after other health insurance coverage ends, if later. Retiree's c**overage will begin when other health coverage ends. There must be no lapse in health insurance coverage. The same rule applies to your spouse's coverage (see below).** Note: If there is a return to other coverage after Retiree's coverage becomes effective, Retiree's coverage will be discontinued while the other coverage is in effect. **If you or your spouse is covered by COBRA or have other coverage, it is your responsibility to notify the Administrative Office when it begins and when it ends. Proof of continuous other health insurance for the 24 months immediately preceding the activation of Retiree's coverage is required before coverage under this Plan can begin or resume.**
Spouse Coverage:	Retiree's Welfare Trust assumes you want coverage for your spouse if you are married. Your spouse's coverage will begin at the same time as yours, unless your spouse has other coverage when your coverage starts. In this case, your spouse will be required to Suspend (postpone) spouse coverage as indicated above until the other coverage has ended. Note: If you and your spouse are covered by the Retiree's Plan, and you die before your spouse, your spouse may elect to continue coverage pursuant to the terms of the Plan (see Plan Book). In addition, a new Spouse may be added to coverage if you marry after your initial retirement date. The new spouse must be enrolled within 60 days of the date of marriage and the new spouse must have had continuous medical insurance coverage in the 12 consecutive months ending with the month in which the date of marriage occurred (see Plan Book). **If you do not want spouse coverage, you must opt out by declining spouse coverage. If you check Yes on the application to decline spouse coverage, or you decline spouse coverage any time in the future, your spouse will not be eligible to re-qualify under this Plan at any time thereafter.**
Monthly Self-Payments:	Eligible Retirees, spouses/dependents (if applicable) are required to remit self-payment through Electronic Funds Transfer (EFT) to maintain coverage. With EFT, your monthly self-payment will automatically be deducted from your bank account on the **5th of each month** (or the next business day if it is a weekend/holiday). Once your EFT is established, you will not receive a monthly statement or billing; the amount of the deduction will be listed on your bank statement. Self-pay amounts differ depending on whether the retiree and/or spouse are eligible for Medicare. Upon approval of your application, you will be sent an initial billing that lists your self-payment rate(s). Failure to make self-payments when due will result in permanent termination of Retiree coverage**.** The Trustees reserve the right to adjust self-payment rates or benefits. If your Retiree's coverage is termed for a reason other than Suspension (you have other insurance), you will not be able to later reinstate coverage.
Disability:	If you are disabled, under age 50, and meet the disability coverage requirements, the age 50 requirement may be waived provided that you have a Social Security disability award. A copy of the award letter is required before eligibility for coverage can be determined.
Address Change & Marital Status:	Please notify Northwest Administrators, Inc. in writing of any future change of address and/or any change in your marital status.

RETIREE'S WELFARE TRUST

Application for Coverage

INSTRUCTIONS:
Review EACH section. Use INK. PRINT.
SIGN and DATE on page 2
For questions, call **(800) 692-5179**

MAIL TO:
Retiree's Welfare Trust
2323 Eastlake Ave E
Seattle WA 98102-3393

RETIREE INFORMATION

Social Security #	☐ Mr. ☐ Mrs. ☐ Ms. Your Name: (Last)	(First)	(MI)	Birth Date	Gender
Phone Number ( ) -	Physical Street (or RFD No.) Address	(City)	(State)	(Zip)	
If you are under 50, are you eligible for PEER under WCTPTF at retirement? ☐Yes ☐No	Mailing Address (if different)	(City)	(State)	(Zip)	
	E-mail Address				Local Union#

EMPLOYMENT INFORMATION

List the Employer(s) you worked for in the last five (5) years - Begin with your most recent employer. List all employers even if they did not pay into the Trust. (If additional space is needed, attach sheet.)

EMPLOYER	FROM	TO	TEAMSTER (YES / NO)
1.			
2.			

Date of Retirement from Teamster Covered Employment:	Were you disabled at any time during the 48 months before your retirement from Teamster Covered Employment? ☐Yes ☐No **If yes**, list dates of disability: _____
Last day worked (any employment):	Do you qualify for Social Security Disability benefits? ☐Yes ☐ No **If Yes, please send a copy of the Social Security Disability Award Letter with this application.** Social Security Disability effective date: _____

SPOUSE/DEPENDENT INFORMATION

Are you married? ☐Yes ☐No If you are married at the time your coverage commences, your spouse at that time is also covered (unless you Decline spouse coverage or your spouse has Other Insurance). If you wish to Decline spouse coverage, please contact the Administrative Office.
If your spouse/dependent(s) have <u>Other health insurance</u> at the time your coverage starts, your spouse's coverage under this Plan must be Suspended (Postponed) until the Other coverage terminates. Complete the Other Insurance Information below to Suspend coverage.

Date of Marriage	Spouse's Name	Spouse's Social Security #	Spouse's Birth Date	Spouse's Gender

Is Spouse only requesting coverage because the Retiree is deceased? ☐Yes ☐ No **If Yes**, attached the Retiree's death certificate.

Do you have dependent children under 19 (or disabled) to cover under this Plan ? ☐Yes ☐ No **If Yes,** list Dependent(s) below.
Dependent children can only be covered <u>until age 19</u>. To request coverage for a disabled child (at any age) attach disability documentation.

DEPENDENT NAME (attach list if additional space is needed)	SOCIAL SECURITY #	DATE OF BIRTH	GENDER

OTHER INSURANCE CERTIFICATION

IMPORTANT – If you or your spouse/dependents have or obtain any Other health insurance coverage (not including Medicare) you must Suspend (Postpone) coverage under this Plan. If you Suspend coverage under this Plan, your spouse/dependents must also Suspend. Following termination of the Other Insurance, you are required to provide Proof of Other insurance coverage that shows continuous coverage for the 24 months immediately preceding reactivation of this Retiree's Welfare Trust coverage. **There can be no lapse in health insurance coverage**.

Not including Medicare, will you or your spouse/dependents have any Other health insurance coverage (including COBRA) after your Teamster Covered Employment ends?
☐Yes ☐No If No, your coverage under this Plan will be effective following your retirement date/loss of employer provided coverage.

If Yes, you **must** provide the Other insurance information below.

Is the health insurance coverage provided through? ☐COBRA ☐Employment of you/your spouse ☐Private Policy	Who is insured under this policy? ☐Self ☐Spouse ☐Full Family	Effective date:

Group #	Policy #	Name, address/phone# of insurer:	Is the coverage still active? ☐Yes ☐No	If No, Term Date:

(Continue on Reverse Side)

MEDICARE INFORMATION

Are you or your Spouse/Dependents eligible for Medicare? ☐Yes ☐ No **If No, skip this section.**

If Yes, complete below and attach a copy of Medicare or Social Security Disability Award Letter(s) or Medicare card(s). This Retiree coverage will be at a reduced Medicare Supplement rate. **You must maintain Medicare Parts A and B** and this coverage will be a Supplement to Medicare. We will send you a form to elect Medicare Part D (Prescription) coverage for no additional cost.

MEDICARE COVERAGE	FOR YOURSELF	FOR YOUR SPOUSE
Part A (Hospital Services)	☐Yes ☐No If Yes Effective Date: _____	☐Yes ☐No If Yes Effective Date: _____
Part B (Medical Services	☐Yes ☐No If Yes Effective Date: _____	☐Yes ☐No If Yes Effective Date: _____
On Medicare due to End Stage Renal Disease?	☐Yes ☐No If Yes, first treatment:_____	☐Yes ☐No If Yes, first treatment:_____
Please provide Medicare ID Number(s)	**MBI#:**	**MBI#:**

NON-MEDICARE COVERAGE WAIVER OPTION

If you wish to waive (Opt-out) of Non-Medicare coverage under this Plan review the following (otherwise skip this section).

If you are not yet eligible for Medicare, you may choose to waive Non-Medicare coverage under this Plan and wait until you become eligible for Medicare to activate the Medicare Supplemental Plan. Once you choose this option it is irrevocable under any circumstances. Your spouse must also wait for coverage until eligible for Medicare. Dependent children cannot be covered. Contact the Trust office for more information.

☐ **I want to opt-out of Non-Medicare coverage as described above. Please send me a Non-Medicare Waiver Election Form.**

CERTIFICATION OF INFORMATION

I hereby apply for coverage under the Retiree's Welfare Trust for myself and my spouse (unless declined). I certify the information I provided above is correct and I have read the information regarding the Suspension of plan benefits on the attachment. I authorize any person or institution providing care or services, or any organization possessing insurance benefit information, to release any and all information pertaining to the care or benefits provided to me, my spouse or covered dependents. I understand if my last contributing employer ceases participation in the Trust for any reason after my retirement, I (we) may be required to pay additional premiums for coverage.

RETIREE'S FULL SIGNATURE:_____ **DATE:**_____

RETIREE'S PRINTED NAME:_____

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

SPOUSE'S PRINTED NAME: _____

Administrative Use Only

Fund: _____ Plan: _____ COBRA Account No: _____ Participant Age: _____

Rate: _____ Effective Date: _____ COBRA Term Date: _____ Spouse Age: _____

Yr:	**Yr**:	**Yr**:	**Yr**:	**Yr**:	**Yr**:	**Yr**:	**Yr**:	**Yr**:	**Yr**:
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: RWT PLUS _____/_____ RWT PLUS XL _____/_____