

ARIZONA SHEET METAL TRUST FUNDS

HEALTH AND WELFARE

ADMINISTRATIVE OFFICE

PENSION

2400 W. Dunklap Ave., Suite 250
Phoenix, AZ 85021
(602) 249-3582
www.southwestservicepa.com

Retiree Medical Plan Enrollment

If you are inquiring/applying for Pension Benefits and are interested in continuing medical coverage under the Retiree Plan, this information may be of interest to you. In order to determine if you qualify for this Plan you must complete the Medical Plan Enrollment Form. The base criteria for acceptance into the Plan according to the SPD (Summary Plan Description) is as follows:

To be eligible to make this election, a former Eligible Employee must have been covered by this Fund for benefits for at least ten (10) years, and must have been covered for six (6) months out of the last twenty four (24) months prior to retirement (at least three (3) of these coverage months must have been employment-generated). The six in the last twenty-four month requirement is waived if the former Eligible Employee was covered by this Fund for at least twenty five (25) years.

Please note, receipt of this information or completion of the enrollment form does not guaranty acceptance into the Plan.

It is highly recommended that you review the SPD to understand the benefits available to you and your covered dependents should you qualify. If you or your dependent(s) are entitled to Medicare you will receive the same benefits as described in the SPD, **less** benefits provided by Medicare. This is commonly referred to as a Medicare carve-out benefit. **It is very important for you and your dependent(s) to subscribe to Part B of Medicare (if entitled).** If you have any questions on your Retiree benefits, please contact Customer Service at (602) 249-3582 or if outside Arizona, toll-free at (800) 474-3485.

Please complete the Medical Plan Enrollment form found on the following page and return to the Trust Fund office at your earliest convenience. If you have any questions you may contact the Trust Fund office at the number noted above.

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RETIREE MEDICAL PLAN ENROLLMENT APPLICATION

NAME: _____ SSN: _____
FIRST MI LAST

DATE OF BIRTH: _____ PHONE NUMBER: _____

ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP

RETIREMENT EFFECTIVE DATE _____ LAST DAY WORKED: _____

NAME OF LAST EMPLOYER: _____

ELIGIBLE FOR MEDICARE BENEFITS? YES NO ELIGIBLE TO RECEIVE SOCIAL SECURITY DISABILITY? YES NO
(IF YES, ATTACH A COPY OF YOUR MEDICARE CARD) (IF YES, ATTACH A COPY OF YOUR AWARD LETTER)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SPOUSE'S NAME: _____ SSN: _____ DATE OF BIRTH: _____

SPOUSE ELIGIBLE FOR MEDICARE BENEFITS? YES NO
(IF YES, ATTACH A COPY OF HIS/HER MEDICARE CARD)

OTHER DEPENDENT INFORMATION: IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

NAME: _____ SSN: _____

DATE OF BIRTH: _____ RELATIONSHIP: _____

NAME: _____ SSN: _____

DATE OF BIRTH: _____ RELATIONSHIP: _____

I HEREBY **WAIVE** ENROLLMENT IN THE ARIZONA SHEET METAL RETIREE MEDICAL PLAN. I UNDERSTAND THAT ONCE I WAIVE ENROLLMENT, I WILL NOT BE ABLE TO ENROLL AT A LATER DATE.

I HEREBY **ELECT TO ENROLL** IN THE ARIZONA SHEET METAL RETIREE MEDICAL PLAN. I UNDERSTAND THAT THIS APPLICATION MUST BE REVIEWED BEFORE ELIGIBILITY FOR THE RETIREE MEDICAL PLAN IS APPROVED. I UNDERSTAND THAT IF APPROVED, THE MONTHLY RETIREE MEDICAL PREMIUM WILL BE DEDUCTED FROM MY MONTHLY PENSION CHECK. IF THE AMOUNT CANNOT BE DEDUCTED FROM MY MONTHLY PENSION CHECK, I WILL BE RESPONSIBLE FOR MAILING THE PREMIUM TO THE ADMINISTRATIVE OFFICE EVERY MONTH. I ALSO UNDERSTAND THAT THE BOARD OF TRUSTEES MAY BE REQUIRED TO ADJUST THIS MONTHLY PREMIUM FROM TIME TO TIME.

Medical Premium Election when Medical Effective Date is before Pension Approval

I choose to self-pay my retiree medical plan premium(s) if the amount cannot be deducted from my pension benefit prior to the medical plan effective date.

I hereby authorize the Arizona Sheet Metal Pension Trust Fund to withhold the retiree medical plan premium from my monthly pension benefit. I understand I may have to pay up front for health care expenses for which I may request reimbursement once coverage has been retro-actively reinstated. **This option is available only if your retirement effective date is less than 11 days before board approval.**

Signature

Date

Spouse's Signature (If Married)

Date