

SMWIA Local 49 Family Health Plan

Administrative Office
2400 West Dunlap Avenue, Suite 250 • Phoenix, Arizona 85021
Phone 505-265-8422 • Toll Free 1-800-432-6636

RETIREE MEDICAL PLAN ENROLLMENT APPLICATION

Please Print

1. Name _____
First Middle Last
2. S.S. # _____ 3. Phone # () _____
4. Address _____
City State Zip
5. Date of birth _____ 6. Date retired _____
7. Were you an active participant in the SMWIA Local 49 Family Health Plan for the last 24 months preceding your retirement date? Yes No
Last day worked _____ Name of last employer _____
8. Have you applied for pension benefits? Yes No Date applied _____
9. Are you enrolled in the Sheet Metal Workers National Pension Fund? Yes No
(If yes, please attach award letter)
10. Are you eligible for Medicare benefits? Yes No
11. If yes, are you enrolled in both parts A & B or part C? Yes No

NOTE: COMPLETE THIS SECTION ONLY IF YOU WISH TO ALSO ENROLL YOUR ELIGIBLE SPOUSE AND/OR DEPENDENTS

12. Spouse's name _____
13. S.S. # _____ 14. Date of birth _____
15. Is your spouse eligible for Medicare benefits? Yes No
16. Is your spouse covered by another health plan? Yes No
17. Dependent's name _____
18. Date of birth _____
19. Is your dependent covered by another health plan? Yes No

I hereby elect to enroll in the SMWIA Local 49 Retiree Family Health Plan.

My initial payment of \$ _____ is enclosed.

PLEASE MAKE CHECK PAYABLE TO SMWIA LOCAL 49 FAMILY HEALTH PLAN

I understand that the Board of Trustees may be required to adjust this monthly contribution rate.

Signature _____ Date _____