Insulators and Allied Workers National Medical Fund
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Administered by: NEBA

APPLICATION FOR RETIREE MEDICAL BENEFITS

SECTION 1: PARTICIPANT INFORMATION			
Member Name:		**SSN (last 4 digits):**	
Address:			
Email Address:		**Date of Birth:**	
Telephone #:		**Local Union:**	

SECTION 2: CERTIFICATION OF ELIGIBILITY FOR RETIREE MEDICAL BENEFITS

Instructions: Please indicate that you are eligible for Retiree Medical Benefits by checking the Certification below and filling in your retirement date, if applicable to you.

☐ **Certification 1.** I certify that I retired on _____. I further certify that (1) I was eligible for benefits from the Insulators and Allied Workers National Medical Fund on the date I retired; or
(2) I worked for the International Union, the AFL-CIO, a Building Trades Council, or if approved by the Board of Trustees, a related organization whose purpose is to promote the unionized insulation industry, from the time I was last eligible under the Medical Fund until retirement.

Instructions: Please indicate that you are eligible for Retiree Medical Benefits by checking **one** of the following additional Certifications, if applicable to you.

☐ **Certification 2A. IAW National Pension Entitlement.** I certify that I am receiving (or I have applied for and am entitled to receive) a pension (other than a deferred pension) from the Insulators and Allied Workers National Pension Fund.

☐ **Certification 2B. Other AWLU Local Union Pension Entitlement.** I certify that I am receiving (or I have applied for and am entitled to receive) a pension (other than a deferred pension) from the Pension Fund of Local Union #_____.

☐ **Certification 2C. Total and Permanent Disability.** I certify that I am totally and permanently disabled and am entitled to receive a Social Security Disability Benefit. (***Please submit a copy of your Social Security Administration award letter with this application.***)

☐ **Certification 2D. Production Worker or NBU Office Staff.** I certify that I am a Production Worker or Non-Bargaining Unit Office Staff Person who: (1) is at least 58 years old with five or more years of eligibility immediately prior to retiring; or (2) is at least 58 years old with ten or more years of participation prior to retiring with less than a three-year break in eligibility prior to retiring.

☐ **Certification 2E. Employee with Ownership Interests in an Employer who was covered by the Special Participation Agreement for Employees with Ownership Interests.** I certify that I am an Employee with Ownership Interests in an Employer who was covered by the Special Participation Agreement for Employees with Ownership Interests and am receiving a pension (other than a deferred pension) from the pension fund of a Local Union participating in this Fund, from the Insulators and Allied Workers National Pension Fund, from the pension plan of an Employer signatory to a Collective Bargaining Agreement or a retirement benefit from the Social Security Administration.

SECTION 3: RETIREE BENEFIT ELECTION

Instructions: Please make your election for Retiree Benefits by checking the appropriate option that best meets your needs. **You must select one of the two options listed in this section.**

☐ **A. Elect Death Benefits ONLY & Irrevocably Decline Retiree Medical Coverage Forever**

Check here if you elect Retiree Death Benefits ***only.*** This means you will not receive Retiree Medical Coverage and you will not be eligible to enroll in Retiree Medical Coverage in the future. (Do not check this box if you want Retiree Medical Coverage at this time or if you want Retiree Medical Coverage in the future.)

☐ **B. Elect Death Benefits and Retiree Medical Coverage**

Check here if you elect Death Benefits and Retiree Medical Coverage for yourself and/or your Eligible Dependents. (Check this option if you wish to have Death Benefits and Retiree Medical Coverage at any time in the future, even if you do not immediately want the medical coverage.) If you select this option, you must complete Section 4 below.

SECTION 4: EFFECTIVE DATE AND SUSPENSION OPTIONS

Instructions: If you elected Death Benefits and Retiree Medical Coverage, please indicate your requested Retiree Medical Coverage effective date below. Note that Qualified Retirees, spouses and/or Dependents who are covered by other coverage may elect to suspend (i.e., temporarily opt out of) Retiree coverage through the Fund in order to participate in the other coverage. Suspended Retiree, spouse and/or Dependent coverage can be reinstated in the future should you, your spouse and/or Dependent decide to terminate the other coverage.

A. I elect to **enroll** the individuals marked below in retiree coverage, **effective immediately following the termination of my eligibility as an Active Eligible Employee**.

	Name:	***Date of Birth***	***Last 4 of SSN***	***Medicare Eligible?***
☐ Myself				☐ Yes ☐ No
☐ My Spouse				☐ Yes ☐ No
☐ My Dependents				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Signature: _____ **Date:** _____

SECTION 4: EFFECTIVE DATE AND SUSPENSION OPTIONS (CONTINUED)

B. I elect to **suspend** Retiree coverage for the individuals marked below, **effective immediately following the termination of my eligibility as an Active Eligible Employee**, in order to participate in other coverage. ***Retiree Death Benefits will be effective immediately following the termination of your eligibility as an Active Eligible Employee, even if you choose to suspend Retiree Medical Coverage***.

☐ **Myself**	***Name:***	***Date of Birth***	***Last 4 of SSN***	***Medicare Eligible?***
				☐ Yes ☐ No
☐ **My Spouse**	***Name:***	***Date of Birth***	***Last 4 of SSN***	***Medicare Eligible?***
				☐ Yes ☐ No
☐ **My Dependents**	***Name:***	***Date of Birth***	***Last 4 of SSN***	***Medicare Eligible?***
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

I understand that to qualify for reinstatement of suspended Retiree Medical Coverage in the future, I must:

- Submit a written request for reinstatement to the Fund Office 30 days prior to the requested reinstatement date.
- Provide evidence that the individual(s) to be reinstated (myself, and/or my spouse, and/or my dependent(s)) have maintained continuous coverage under a health plan for the entire period of the suspension.

The reinstatement effective date must be the beginning of an Eligibility Quarter: March 1, June 1, September 1, or December 1. **I understand that no benefits will be paid by the Insulators and Allied Workers National Medical Fund for claims incurred during the suspension period.**

Signature: _____ **Date:** _____

Important Note About Medicare Eligibility

If you are eligible for Medicare and enroll in Retiree medical coverage, you must enroll in Medicare Parts A and B. The Plan will then automatically enroll you in a fully-insured Medicare Advantage Prescription Drug Plan provided by United Healthcare and Save-Rx. Under this arrangement, you will have access to a comprehensive prescription drug program at no additional cost to you. You will not need to enroll in a Medicare Part D plan.

Again, to have adequate coverage, you and/or your spouse or Eligible Dependent MUST sign up for Medicare Parts A and B at the earliest possible opportunity. This paragraph applies to you regardless if you or your Eligible Dependent(s) become eligible for Medicare due to age, disability, end-stage renal disease, or any other reason. If you or your covered spouse or dependent become eligible for Medicare in the future, you must notify the Fund Office immediately and send a copy of your Medicare Card.

SECTION 5: PARTICIPANT CERTIFICATION & SIGNATURE

Instructions: Please sign below after reading all of the information in this section. Be sure to ask the Fund Office if you have any questions.

A. Accuracy of Information and Representations.

I hereby apply for and consent to payment of benefits, to which I believe I am entitled, from the Fund. I hereby authorize all action necessary to implement the elections made herein. I certify that the representations made in this Application Form, and any information or proof submitted with this Application Form, are true and correct. I recognize that the Fund is relying on the accuracy and completeness of such representations in making a determination on my Application for benefits, and agree to provide the Fund with any information and proof the Fund deems necessary to determine whether to grant my Application. I understand that any false statement made by me in this Application Form or any fraudulent information or proof I furnish will impede my claim. I further understand that if I have made any false statement or provided fraudulent information or proof, I will be liable to the Fund for any penalties or expenses incurred by the Fund in relying on such statement, information, or proof. Finally, I understand that all payments are governed by the Plan Document, and I agree to reimburse the Fund for any payments not provided by the Plan Document.

B. Coverage Termination.

I understand that coverage will terminate upon my death or failure to make timely quarterly payment, whichever occurs first. By electing Retiree Medical Benefits, I understand that I am waiving my rights to COBRA continuation coverage. If I should die while covered as a Retiree, the eligibility of my Dependents who are covered by my Retiree Medical Benefits at the time of my death will terminate on the last day of the quarter for which a payment has been made for coverage for that Dependent. My widow(er) may continue coverage provided (1) he or she has been married to me for at least one year immediately prior to my death, (2) there is no other group health benefits coverage on the widow(er) (except Medicare) and (3) the qualified widow(er) makes the applicable payment as determined by the Trustees. If my widow(er) is not eligible to continue coverage because he or she had other group health benefits coverage at the time of my death, he or she can elect to have Retiree Medical Benefits reinstated when the other coverage terminates, provided application for reinstatement is made within 60 days after termination of the other coverage. The coverage on a widow(er) will terminate if the widow(er) remarries or fails to make the required payment to continue Retiree Benefits on a timely basis. Dependent children of a deceased Retiree may continue to be entitled to benefits if payments are made on their behalf for as long as they would have been eligible if the Retiree had not died. If the Dependent children are not natural born children of the Retiree, but became Dependents of the Retiree as a result of a marriage less than one year prior to the death of the Retiree, the benefits of such Dependent children will terminate at the death of the Retiree.

Participant's Signature: _____ **Date:** _____

SECTION 6: ADDITIONAL INSTRUCTIONS

Instructions for Participants of the Insulators and Allied Workers National Pension Fund:

If you are a participant of the Insulators and Allied Workers National Pension Fund, the Fund Office will validate your status as a retiree. You may have your retiree coverage premiums deducted from your pension fund payments on a monthly basis. If you wish to do so, please complete the form entitled "**Assignment of Pension Plan Benefits to Insulators and Allied Workers National Medical Fund."**

Instructions for Participants of Another AWLU Local Union Pension Fund: If you are a participant of an AWLU Pension Fund other than the Insulators and Allied Workers National Pension Fund, you must obtain and submit a letter from your Pension Fund administrator verifying your retirement status. ***The Fund Office will not be able to validate your status as a retiree unless you submit this letter.***