NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

935 Detroit Avenue, Suite 242A, Concord, CA 94518-2501 • Phone 925/356-8921 • Fax 925/356-8938
tfo@ncpttf.com • www.ncpttf.com

RETIREE HEALTH AND WELFARE ("RHW") BENEFITS APPLICATION

I, _____, SS# XXX-XX-_____, herein referred to as the Retiree, hereby declare that I and, if applicable, my Spouse, have read and understand the following conditions of RHW Benefits through the Northern California Pipe Trades Trust Funds ("Plan").

Please initial within the box for each item below to confirm that you have read, understand, and meet each of the following requirements.

(Retiree)	(Spouse)	
		I have been formally notified by the Trust Fund Office ("TFO") that Plan records reflect that I am currently eligible for RHW Benefits. I understand that the amount of the monthly premium payable for RHW Benefits is based on: (a) the Retiree's gross monthly Retirement Benefit at Normal Retirement Age; **and** (b) the Medicare status of the Retiree and eligible Dependent(s).
		I understand that the Board of Trustees has established the RHW Plan on the basis that Employer contributions for Active Participants will, if continued, partially maintain this Plan for Retirees. I further understand that the benefits provided by this Plan can be paid only to the extent that the Plan has available adequate resources for those payments. Benefits under this Plan are not vested, and are subject to change or elimination at any time.
		I understand that I and/or my eligible Dependent(s) may be required to pay a portion of the cost of coverage for RHW Benefits.
		I understand that monthly premiums may increase periodically in the future at the Board of Trustees' discretion.
		I understand that to maintain coverage under the RHW Plan, it is my obligation to notify the TFO in writing immediately of the date that I and/or any eligible Dependent(s) become entitled to Medicare coverage. **I understand that once a Retiree or Dependent(s) becomes eligible for Medicare coverage, timely enrollment in Medicare Parts A and B is mandatory.** I understand Medicare Part D is also a requirement for participation in the RHW Plan; however, the TFO will assist in the assignment of Part D through the selected Health Plan. I understand that failure to enroll in Medicare Parts A, B, and D and/or to timely notify the TFO of Medicare entitlement may either result in loss of coverage under the Plan for myself or my Dependent(s) or assessment of additional premium amounts and penalties to continue participation in the Plan.
		I understand that upon a Retiree or Dependent's Medicare entitlement, certain Medicare Benefits must be assigned to only one Health Plan. I understand that if a Retiree or Dependent(s) is enrolled in any other Plan(s) at the time of Medicare entitlement, in order to continue participation in the RHW Plan, the Retiree or Dependent(s) must disenroll from any other Plan(s).
		I understand that I must timely notify the TFO of any change in life circumstances for myself and/or my Dependent(s). I understand that a change in life circumstance may include, but is not limited to, separation, divorce, or Medicare entitlement.
		I understand that RHW Benefits are available only to Members in good standing with UA Local 342. To receive RHW Benefits from the Plan, a Retiree must be a Member of UA Local 342 at the time of Retirement, and at all times must continuously maintain UA Local 342 Union Membership. I understand that if a Retiree loses UA Local 342 Union Membership and/or is no longer considered a Member in good standing, a Retiree and Dependent(s) will lose RHW Benefits effective the 1st of the month following the Retiree's loss of Membership.
		I understand that a Member of UA Local 342 must **not** have worked in non-covered employment in the Plumbing and Pipefitting Industry at any time unless approved by the Board of Trustees. I further understand that if a Retiree works in non-covered employment without approval from the Board of Trustees, eligibility for RHW Benefits (including medical, prescription drug, dental, and vision) would be forfeited for the Retiree and any eligible Dependent(s).
		I understand that I and/or my eligible Dependent(s) may delay enrollment into the RHW Plan with a one-time only option to opt back into the Plan if: (a) the Retiree and Dependent(s) are currently enrolled in another Group Health Plan; **or** (b) until the Retiree or Retiree's Spouse becomes Medicare eligible. The Retiree may be permitted back into the Plan only if: (a) notification is made to the TFO within 30 days of the date the other coverage terminates or the Retiree becomes Medicare eligible and formal evidence, such as proof of Medicare enrollment is timely provided to the TFO; **and** (b) the Retiree meets the Plan's RHW eligibility rules that are in effect on the date the Retiree requests to opt-in to the RHW Plan. I further understand that in order for the Spouse to be eligible to opt back into the Plan based on Medicare enrollment, at the time of the Spouse's Medicare eligibility, the Retiree would have to already be eligible for and enrolled in the RHW Plan.
		I understand that if (a) I and/or my Dependent(s) fail to timely notify the TFO of Medicare entitlement or enroll in Medicare coverage; (b) I knowingly enroll a Dependent who does not meet the Plan's eligibility requirements; or (c) I fail to notify the TFO immediately when any enrolled Dependent(s) no longer meets the Plan's definition of an eligible Dependent that this may be considered fraud and I will be required to repay the Plan for any overpayments resulting from claims and premiums paid as well as reasonable interest, attorney's fees, and any other costs incurred by the Plan in recovering such amounts. I also understand that I will not be eligible for RHW Benefits until either full refund of the overpaid amount is made to the Plan or I sign an Agreement to Repay the Plan in monthly installments as determined by the Plan through deductions from my Retirement Benefit.
		I understand that if I owe monies to the Plan because an ineligible Dependent(s) was maintained in the Plan or I and/or my Dependent(s) failed to timely notify the TFO of Medicare eligibility and/or enroll in Medicare coverage, that any amounts owed may be deducted, offset or paid from other Trust Fund Benefits that may be payable including, but not limited to, payment from any distribution from the Northern California Pipe Trades Supplemental 401(k) Retirement Plan and/or the Northern California Pipe Trades Pension Plan. I understand that by initialing this Form, I am authorizing those Plan(s) to make such deductions or distributions.

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Name: _____ SS#: XXX-XX-_____

In order to apply for RHW Plan Benefits, you must fully complete a Retiree Enrollment/Change Form and all applicable pages of the RHW Benefits Application and where noted, have your signature notarized by a notary public.

All Retirees eligible for RHW Benefits who would be entitled to a gross monthly Retirement Benefit of $1,000 or greater at their Normal Retirement Age under the Single Life Annuity Benefit (excluding any reductions such as under a Qualified Domestic Relations Order) are required to pay a monthly premium to maintain RHW. The amount of the monthly premium payable is currently based on the Medicare status of the Retiree and any eligible enrolled Dependent(s).

Currently, the monthly premium to maintain RHW Benefits, which includes Medical, Prescription Drug, Dental, and Vision, is as follows:

Premium for Retiree		Premium for Legal Spouse		Premium for Dependent Children	
Medicare Parts * A, B, & D Retiree	Non-Medicare Retiree	Medicare Parts * A, B, & D Spouse	Non-Medicare Spouse	Child(ren) of Medicare * Parts A, B, & D Retiree	Child(ren) of Non-Medicare Retiree
$110	$220	$55	$110	$55	$110

***Additional premiums may apply with Medicare Parts B and D, and for other circumstances.**

These amounts are likely to increase in the future. Additionally, Retirees entitled to a monthly Retirement Benefit amount under $1,000 may, in the future, also be required to pay a monthly premium to maintain RHW Benefits.

SELECT THE RETIREE HEALTH AND WELFARE OPTION THAT YOU WISH TO ELECT:

☐ **I wish to apply for Retiree Health and Welfare Benefits for myself and any eligible Dependent(s).**
If you are currently covered under the Active Health and Welfare Plan, your coverage under the Retiree Health and Welfare Plan will become effective on the later of:

- Your Date of Retirement Benefit;
- The first day of the month following exhaustion of your Active Reserve Hour Bank; or
- The first of the month following any Active COBRA Self-Payments.

☐ **I do NOT want to participate or wish to delay applying for Retiree Health and Welfare Benefits for myself and any eligible Dependent(s).**
I understand that should I elect to not participate or delay enrollment, that if I later wish to apply for Retiree Health and Welfare Benefits, my entitlement would be subject to the Plan rules in effect on the date I apply, including, but not limited to, the Plan's eligibility requirements and Opt-In requirements.

☐ **I wish to apply for Retiree Health and Welfare Benefits but wish to delay enrollment for only my eligible Dependent(s).**

ASSIGNMENT OF BENEFITS TO PAY MONTHLY PREMIUM FOR RHW BENEFITS

I hereby authorize the Northern California Pipe Trades Health and Welfare Plan ("Plan") to deduct the premium amount that has been determined by the Board of Trustees of the Plan from my monthly Retirement Benefit payment, in order to maintain my RHW Benefits. This includes any amounts I may owe to the Plan.

I understand that I am under no obligation to enter into this arrangement for the payment of the monthly premium for my RHW Benefits, and that this Assignment of Benefits to the Plan may be revoked by me at any time by advising the Trust Fund Office in writing.

_____ _____
Retiree Signature *Date*

_____ XXX-XX-_____
Print Name *Social Security Number*

OR

I revoke this Assignment of Benefits to the Plan. I understand and acknowledge that by revoking this Assignment of Benefits to the Plan, I am required to remit payment by the 20th of the month **prior** to the month of coverage, in the proper amount and directly to the Bank and I have been provided with the proper information to comply with Plan rules. I understand that I must make timely payments and failure to make timely payments will result in termination of my RHW Benefits through the Plan.

_____ _____
Retiree Signature *Date*

_____ XXX-XX-_____
Print Name *Social Security Number*

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RETIREE / SPOUSE AFFIDAVIT

I certify that I have read and understand all of the RHW Plan rules as set forth in the RHW Benefits Application.

I certify that I will immediately notify the Trust Fund Office if I or any of the Retiree's Dependent(s) have a change in life circumstances. I understand that a change in life circumstance may include, but is not limited to divorce, separation, or Medicare entitlement.

I understand that to receive RHW Benefits from the Plan, the Retiree must continuously maintain UA Local 342 Union Membership. I understand that if the Retiree loses UA Local 342 Union Membership and/or is no longer considered a Member in good standing, RHW Benefits will be terminated.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____

Print Name *Retiree Signature* *Date*

_____

Print Name *Spouse Signature* *Date*

NOTARY ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____

County of _____

On _____ *Date* before me, _____ *Here insert Name of the Officer*, Notary Public,

personally appeared _____ *Name{s} of Signer{s):*

Who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Place Notary Seal Above

_____
Signature of Notary Public