ELECTION FORM
FOR PARTICIPANTS WHO ARE ELIGIBLE FOR PLAN A+ WHO ARE ELECTING PLAN A
EFFECTIVE FOR COVERAGE PERIOD BEGINNING SEPTEMBER 1, 2020

Employee Information:		
Last Name	First Name	Middle Initial (MI)
Mailing Address:	Home Phone Number:	Cell Phone Number *(Optional)*:
	Social Security Number:	Marital Status: ☐ Single ☐ Married
Date of Birth (Month/Day/Year) _____ / _____ / _____	Email address *(Optional)*:	

Dependents. ***Complete this section for each eligible dependent you wish to enroll in Plan A Coverage, along with yourself, for the Coverage Period beginning September 1, 2020***.

In order to have claims processed for your dependents, you must provide the information requested below (even if you have provided the information in the past). Proof must be provided for each dependent you enroll for coverage to become effective. For your Spouse (and stepchildren), you must provide a copy of your marriage certificate; for Children, a copy of the child's birth certificate and adoption paper work, if applicable.

	Last Name, First Name and Middle Initial	Gender	DOB	SS#	Has Other Coverage? Yes/No *	Address, if different than Member
Spouse						
Child						
Child						
Child						
Child						

COMPLETED AND SIGNED ELECTION FORMS MUST BE RECEIVED BY THE FUND OFFICE BY AUGUST 26, 2020 IN ORDER TO BUY DOWN TO PLAN A

***Complete back of this form for any dependents who have other coverage.**

OVER

ELECTION/ACKNOWLEDGEMENT -- PLEASE READ CAREFULLY AND SIGN BELOW

I understand that:

1. I am eligible for health care coverage under Plan A+ but I am instead electing to enroll in Plan A coverage for myself and my eligible dependents as listed above.

2. This election is only effective for the Coverage Period that runs from September 1, 2020 through February 28, 2020.

3. The Fund's Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate any of the benefits provided by the Fund, as well as the eligibility rules for such benefits, at any time and for any reason. This election is irrevocable, and I will not be able to switch this election during the Coverage Period.

I acknowledge by signing this form that I have read and understand this form and all of the information provided by the Fund regarding this election, and that all the information I have provided above is true and correct to the best of my knowledge. Misrepresentation of information can result in termination of coverage and possible other action.

Signature_____ Date_____

HIPAA Special Enrollment Rights Under the Plan

If you do not enroll yourself or dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance. Contact the Fund Office for further information. *Note that these timeframes have been extended temporarily by the U.S. Department of Labor and Internal Revenue Service due to the COVID-19 pandemic, as explained in the Fund's notice of June 4, 2020. Contact the Fund Office for more information if you think this may apply to you.*

Other Health Care Coverage Information:

Complete the following section for each family member who ***currently*** has other medical, prescription drug, dental or vision coverage.

Policyholder's/Dependent's Name:	DOB:	Social Security #:

Name of Insurance Company/Claims Administrator:	Group Number:	Polity Number:

Insurance/Administrator Address and Phone Number:

List all family members covered under other medical, dental or vision plans/insurance (attach additional pages if more than one plan):