KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND

1996 BYPASS SOUTH
LAWRENCEBURG, KENTUCKY 40342

Telephone: (502) 839-8166 **Fax Number: (502) 839-3558**

RETIREE ELECTION FORM
DELAYED ELECTION FOR RETIREE SPOUSE

You as the Spouse of Participant who is currently covered under one of the Fund=s Retiree Plans will only be allowed to enroll for Retiree Program coverage if you do so within thirty (30) days of the loss of your other medical insurance coverage. If you fulfill this requirement, you must complete this form in full and return it to the Fund Office. In addition you MUST also submit the following information:

1. Proof of the loss of your other medical insurance coverage which shows the date that said coverage terminated. (This documentation should be from the insurance carrier from which your coverage terminated.)
2. If you are eligible for Medicare, you must also submit a copy of your Medicare card showing the date you initially became eligible for Medicare.

You and your spouse will each have your own Retiree coverage, based on the elections of Retiree Plans that you both make. Therefore, you will each receive monthly billings for your self payments. For your own bookkeeping purposes, you may wish to issue separate checks each month. When you submit this Retiree Election Form, you must also submit your check or money order for the amount of self payments owed retroactive to the effective date of your retiree coverage to the present date. If you have questions as to the amounts that are owed, please call the Fund Office at 1-800-798-5300. You and your spouse will each receive monthly billings. **Please note that you and your spouse will always be responsible for submission of self payments by the deadline in the Plan, whether or not you receive a billing.** The monthly deadline for Retiree Self Payments is the 30th day of the eligibility month for which you are making self payment.

PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME OF RETIREE SPOUSE WHO IS ELECTING COVERAGE	First:_____M.I._____Last:_____
RETIREE SPOUSE=S SOC. SEC. #	
RETIREE SPOUSE=S BIRTHDATE	Month:_____ Day:_____ Year:_____
RETIREE SPOUSE=S PHONE #	
RETIREE SPOUSE=S ADDRESS	Street or PO Box: _____ City / State/ Zip: _____
NAME OF RETIRED MEMBER	First:_____M.I._____Last:_____
RETIRED MEMBER=S SOC. SEC. #	

I WOULD LIKE THE EFFECTIVE DATE OF MY RETIREE SPOUSE COVERAGE TO BE:	**Month: Year:**

I, the Spouse of the Retired Participant, elect to continue coverage under the following Retiree Plan: (check Y one)

AGE 64 AND UNDER (& Not Eligible for Medicare)	**AGE 65 AND OLDER (or Eligible for Medicare)**
Please check [Y] ONE of the following:	**RETIREE PLANS: (If you are NOT eligible for Medicare you will select Class Code RH. If you ARE eligible for Medicare you will select Class Code RI.)**
	Retiree Plan H - Class Code RH - (Under Age 65 and NOT Eligible for Medicare)
	Retiree Plan H - Class Code RI - (Age 65 or Older AND / OR Eligible for Medicare)

PLEASE REFER TO ENCLOSED FORM WHICH GIVES MONTHLY RATES

I have enclosed check/money order for self payments retroactive to my effective date of coverage as follows:

	MONEY ORDER OR CHECK NUMBER	CHECK AMOUNT	NUMBER OF MONTHS PAID	PAID FROM (Month / Year)	PAID TO (Month / Year)

I certify that all statements are true and complete to the best of my knowledge and belief. I understand false statements or incomplete answers may cause employee and/or dependent continuation coverage to be terminated. I understand it is my responsibility and that of my spouse, to immediately notify the Fund Office if any of the information provided on this form changes for any reason. I will notify the office if I or my spouse become eligible for other group medical insurance or Medicare.

DATE:	**SIGNATURE OF SPOUSE:**