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 – INITIAL ELECTION

You as the Retired Participant and, if applicable, your spouse must complete this form in full. The form must be returned to the Fund Office by the deadlines specified in the Notice of Options for Active and Retiree Health Coverage which was included in your COBRA Election Notice sent to you at the time your Active insurance terminated due to insufficient hours. You will not be sent another Retiree Election Form. You may, however, contact the Fund Office and request another Retiree Election Form.

You and your spouse will each have your own Retiree coverage, based on the elections that you both make on this form. 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 1-800-598-7330. You and your spouse will begin receiving the monthly billings as of the month following the month in which your Retiree Election Form has been received. **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 1st day of the eligibility month for which you are making self payment.

RETIRED PARTICIPANTS MUST COMPLETE SECTIONS 1 & 2. RETIRED PARTICIPANT'S SPOUSES MUST COMPLETE SECTION 3. BOTH THE RETIRED PARTICIPANT AND HIS SPOUSE MUST COMPLETE SECTION 4 AND MUST SIGN AND DATE THE FORM.

S E C T I O N 1 (TO BE COMPLETED BY RETIRED PARTICIPANT)

Participant	Spouse
Participant's Name: ______________________ **(Last) (First) (M.I.)**	Spouse's Name: ______________________ **(Last) (First) (M.I.)**
Participant's Social Security Number:	Spouse's Social Security Number:
Participant's Birth Date:	Spouse's Birth Date:
Participant's Address: ______________________ **(Street or P. O. Box)** ______________________ **(City) (State) (Zip)**	Spouses Address: ______________________ **(Street or P. O. Box)** ______________________ **(City) (State) (Zip)**
Participant's Telephone #:	Spouse's Telephone #:

YES	NO	I HAVE READ AND UNDERSTAND THE NOTICE OF RIGHT TO CONTINUE ACTIVE GROUP HEALTH COVERAGE (COBRA) AND THE NOTICE OF OPTIONS FOR ACTIVE AND RETIREE HEALTH COVERAGE .
		I elect to continue coverage under the Retiree Plan(s) for myself and, if applicable, my spouse.
		I am at least 55 years of age.
		I retired as of ____________ **(Month/Day/Year)** and ceased actively working as a laborer as of ____________ **(Month/Day/Year)**
		I became totally and permanently disabled and unable to work as a laborer as of ____________ **(Month/Day/Year)**

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

NOTE: Both you and your spouse must complete the reverse side of this form.

PLEASE REFER TO ENCLOSED FORM WHICH GIVES MONTHLY RATES
If you are Age 64 or under, you will only be eligible for the lower self payment rate the Retiree Plan you choose if you are eligible for Medicare. If you are not eligible for Medicare, then you must pay the higher self payment rate for the Retiree Plan you choose. **Therefore, if you are eligible for Medicare, you must submit a copy of your Medicare card with this Retiree Election Form .**

SECTION 2 (TO BE COMPLETED BY THE RETIRED PARTICIPANT)

I, the **Retired Participant**, hereby elect to continue coverage under the following Retiree Plan: (check ✔ one)

Please check [✔] 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)

I, the **Retired Participant, DO NOT** elect to continue coverage under a Retiree Plan at this time. (check ✔ if you do not elect Retiree coverage at this time)	**(check ✔)**

SECTION 3 (TO BE COMPLETED BY THE RETIRED PARTICIPANT'S SPOUSE)

I, the **Retired Participant's Spouse**, hereby elect to continue coverage under the following Retiree Plan: (check ✔ one)

Please check [✔] 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)

I, the **Retired Participant's Spouse, DO NOT** elect to continue coverage under a Retiree Plan at this time. (check ✔ if you do not elect Retiree coverage at this time) **NOTE TO RETIREE SPOUSES: If you are NOT electing Retiree Plan coverage at this time, you MUST submit proof that you currently have medical insurance coverage.**	**(check ✔)**

SECTION 4 (TO BE COMPLETED BY THE RETIRED PARTICIPANT & HIS SPOUSE)

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)
RETIREE					
SPOUSE					

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 RETIRED PARTICIPANT:
DATE:	SIGNATURE OF SPOUSE: