I.B.E.W. LOCAL 332 PENSION TRUST FUND

ADMINISTRATIVE OFFICES
1120 S. BASCOM AVENUE, SAN JOSE, CA 95128-3590
(408) 288-4400

APPLICATION FOR COVERAGE AS A RETIREE
I.B.E.W. LOCAL 332 HEALTH & WELFARE
PRE-FUNDED RETIREE PLAN OF BENEFITS

I hereby make application as a Retiree for the IBEW Local #332 Health & Welfare Pre-Funded Retiree Plan of Benefits. The following requirements must first be met at the time of retirement under the IBEW Local #332 Pension Plan.

Date of Retirement _____

You will be eligible for coverage under the Pre-Funded Early Retiree Plan if:	Yes	No
1) You have had 120 months of coverage in the last 180 months under the I.B.E.W. Local 332 Health and Welfare Plan as an active participant and were eligible under the Plan immediately prior to your retirement date; and	☐	☐
2) You are between the ages of 57 and 65; and	☐	☐
3) You have exhausted your Bank Reserve • Coverage months include coverage earned as a result of employer contributions, self-pay, or coverage earned as a result of reciprocal transfers of employer payments. • If you have not used the full 60 months of coverage, but you reach age 65, your coverage under the Pre-Funded Early Retiree Plan will terminate. Coverage will also terminate for your spouse regardless of his or her age.	☐	☐

ELIGIBLE RETIREE AND/OR SPOUSE WHO ARE UNDER AGE 65 AND WHO ARE NOT COVERED BY MEDICARE:
a) Each has the option to enroll in PacifiCare, Kaiser or Health Net. Please refer to pages 49 and 50 of your Benefit Plan Booklet for further information.

ELIGIBLE RETIREE AND/OR SPOUSE WHO ARE AGE 65 OR OVER AND ARE COVERED BY MEDICARE: a) Are not allowed to participate in the Self-Funded Plan; b) Each have the option to enroll in one of three HMO Plans: Kaiser, Health Net, or Secure Horizons; c) May obtain reimbursement of up to $150.00 per month per eligible retiree or spouse for a supplemental Medicare Plan in their area if the retiree lives outside any geographic area served by any of the three HMO's (Monthly proof of supplemental plan enrollment is required). The Trust Fund requires an assignment of Medicare benefits to the HMO plan.

Pre-Funded Plan Retirees are eligible for the Self-Funded Dental Plan, receive vision benefits through the VSP Plan, and are eligible for hearing care benefits through the Self-Funded Plan.

I understand that instead of retiree coverage, I may self-pay to extend my active plan coverage for a limited time under the federal law known as COBRA. This coverage will cost at least $ _____ per month and will end after 18 months. By applying for the Pre-Funded Retiree Plan, I am waiving my right to COBRA coverage.

_____ _____
Retiree SS# Retiree Name (Please Print)

_____ _____
Date of Application Retiree Signature

Return this application to:

Board of Trustees
IBEW #332 Health & Welfare Trust Fund
P.O. Box 5057
San Jose, Ca 95150-5057

☐ APPLICATION APPROVED ☐ APPLICATION DENIED

I.B.E.W. LOCAL 332 PENSION TRUST FUND

ADMINISTRATIVE OFFICES
1120 S. BASCOM AVENUE, SAN JOSE, CA 95128-3590
(408) 288-4400

APPLICATION FOR COVERAGE AS A RETIREE
I.B.E.W. LOCAL 332 HEALTH & WELFARE
RETIREE PLAN OF BENEFITS

I hereby make application as a Retiree for the IBEW Local #332 Health & Welfare Pre-Funded Retiree Plan of Benefits. The following requirements must first be met at the time of retirement under the IBEW Local #332 Pension Plan.

Date of Retirement _____

	Yes	No
1) Must be age 62 or over at the time of retirement under the I.B.E.W. Local 332 Pension Plan Date of Birth: _____	☐	☐
2) Must be receiving Social Security benefits.	☐	☐
3) Must have a minimum of 60 consecutive months of coverage under the Health & Welfare Plan in order to qualify for the Retiree Plan and must also be covered under the Health & Welfare Active Plan of benefits immediately prior to changing to the Retiree Plan of benefits,	☐	☐

ELIGIBLE RETIREE AND/OR SPOUSE WHO ARE UNDER AGE 65 AND WHO ARE NOT COVERED BY MEDICARE: a) Each must make a monthly payment to the plan of $50.00; b) Each have the option to enroll in PacifiCare, Kaiser or Health Net. Please refer to pages 45 thru 48 of your Benefit Plan Booklet for further information.

ELIGIBLE RETIREE AND/OR SPOUSE WHO ARE AGE 65 OR OVER AND ARE COVERED BY MEDICARE: a) Are not allowed to participate in the Self-Funded Plan; b) Have the option to enroll in one of three HMO Plans: Kaiser, Health Net, or Secure Horizons; c) May obtain reimbursement of up to $150,00 per month per eligible retiree or spouse for a supplemental Medicare Plan in their area if the retiree lives outside any geographic area served by any of the three HMO's (Monthly proof of supplemental plan enrollment is required). The Trust Fund requires an assignment of Medicare benefits to the HMO plan.

Retirees are eligible for Dental benefits or Life/AD&D benefits, but they do receive the vision and hearing care benefits through the Self-Funded Plan.

I understand that instead of retiree coverage, I may self-pay to extend my active plan coverage for a limited time under the federal law known as COBRA, This coverage will cost at least $ _____ per month and will end after 18 months, By applying for the Retiree Plan, I am waiving my right to COBRA coverage.

_____ Retiree SS#

_____ Retiree Name (Please Print)

_____ Date of Application

_____ Retiree Signature

Return this application to:

Board of Trustees
IBEW #332 Health & Welfare Trust Fund
P.O. Box 5057
San Jose, Ca 95150-5057

☐ APPLICATION APPROVED

☐ APPLICATION DENIED