WESTERN TEAMSTERS WELFARE TRUST

C/o Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102
(206) 726-3218

You must complete this application and forward it to the Administrative Office either prior to your retirement date or no later than **60 days** following your retirement date or exhaustion of COBRA coverage under an active health plan. **An application submitted later than 60 days following your retirement date or exhaustion of COBRA coverage will not be approved, therefore, you and your dependents will not qualify for coverage**. You will be required to make monthly self-payments for yourself and your spouse (**if coverage is elected for your spouse**). There are, however, some exceptions to the above requirements if you retire because of total disability. The Administrative Office will notify you of the applicable self-payment rates upon receipt of your application. Please review the Plan booklet in its entirety as the provisions therein govern your rights and obligations under the Western Teamsters Welfare Trust.

Please Detach Application Here

WESTERN TEAMSTERS WELFARE TRUST - APPLICATION FOR COVERAGE

Social Security Number	☐ Mr. ☐ Mrs. ☐ Ms. Participant Name: (Last) (First) (MI)			
Phone Number	Street (or RFD No.) Address (City) (State) (Zip)			
Date of Birth	Date of Retirement	Last Day of Active Employment	Will Receive ☐ Regular Pension Benefit ☐ Disability Pension Benefit	Local Union No.
Are you married? ☐ Yes ☐ No	Do you wish coverage for your Spouse? ☐ No ☐ Yes, if Yes your Spouse's Name: (If your spouse has other Group Insurance as a result of employment you can request a postponement of spousal coverage. See reverse side for details on how to apply.)			
Spouse's Social Security Number	Spouse's Date of Birth	Name and Address of Spouse's Employer, if applicable		

Do you wish to receive an application to postpone your Retirees health coverage for either yourself or your spouse? ☐ **No** ☐ **Yes**

If Yes, who are you requesting coverage be postponed for**:** ☐ **Self** ☐ **Spouse only** ☐ **Joint postponement**

(See the back of this application for information on Postponement of Retirees Health Coverage.)

List Dependent Children ______________________________ Date of Birth ______________

______________________________ ______________

Please indicate which Administrative Office processed your application for Western Conference of Teamsters Pension Trust Fund benefits
☐ Seattle, WA ☐ San Mateo, CA ☐ Los Angeles, CA

LIST THE EMPLOYER(S) FOR WHOM YOU HAVE WORKED DURING THE PAST SEVEN YEARS

Begin with last employer. If working as a casual during the time period, indicate dates of casual employment. This information is required to determine if you meet the requirements for eligibility. (If additional space needed, use the back of this form.)

EMPLOYER	FROM	TO
1.		
2.		
3.		

CERTIFICATION OF INFORMATION

Application is hereby made for coverage under the Western Teamsters Welfare Trust for myself and spouse (if elected). I hereby certify that the above information is correct. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information, to release any and all information pertaining to the care or benefits provided to me or my Spouse. I also understand that if my last contributing employer, as defined by the plan, ceases participation under the Western Teamsters Welfare Trust for any reason subsequent to my retirement, I (We) may be required to pay an additional premium to continue coverage.

YOUR FULL SIGNATURE ______________________________ **DATE** ______________

SPOUSE'S FULL SIGNATURE ______________________________ **DATE** ______________

WESTERN TEAMSTERS WELFARE TRUST – IMPORTANT INFORMATION, PLEASE READ

Postponement of Retirees Coverage: Western Teamsters Welfare Trust allows retirees and spouses to postpone the commencement of their Retirees Plan coverage while they have other employment-related group health coverage. To request a postponement of your retirees health coverage for either yourself or your spouse, a Request to Suspend or Postpone Retirees Coverage application must be completed and approved by your Area Administrative Office. **Please note, though that your spouse cannot continue participating in the Retirees Plan if you, as the Retiree, suspend your coverage.** Contact the Administrative Office if you wish to postpone coverage.

Monthly Self-Payments: A monthly self-payment is required for eligible Retirees and dependent spouses (if applicable) to maintain coverage. The amount differs depending on whether the Retiree and/or spouse are eligible for Medicare. Upon approval of your application, you will receive a coupon booklet which lists the applicable self-payment rates. Failure to make any required self-payments will result in permanent termination of Retiree benefits**.**

Disability: If you are disabled, it is possible that the monthly self-payment may be waived during the period that you are waiting for Medicare, provided that you have a Social Security disability award. A copy of the award letter is required before this can be determined.

Address Change: Please notify your Area Administrative Office of any future change of address.

Marital Status: Please notify your Area Administrative Office of any change in your marital status.

ADMINISTRATIVE USE ONLY

1____	1____	1____	1____	1____	1____	1____	1____	1____	1____
2____	2____	2____	2____	2____	2____	2____	2____	2____	2____
3____	3____	3____	3____	3____	3____	3____	3____	3____	3____
4____	4____	4____	4____	4____	4____	4____	4____	4____	4____
5____	5____	5____	5____	5____	5____	5____	5____	5____	5____
6____	6____	6____	6____	6____	6____	6____	6____	6____	6____
7____	7____	7____	7____	7____	7____	7____	7____	7____	7____
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9____	9____	9____	9____	9____	9____	9____	9____	9____	9____
10___	10___	10___	10___	10___	10___	10___	10___	10___	10___
11___	11___	11___	11___	11___	11___	11___	11___	11___	11___
12___	12___	12___	12___	12___	12___	12___	12___	12___	12___
TL___	TL___	TL___	TL___	TL___	TL___	TL___	TL___	TL___	TL___

ELIGIBILITY RESULTS:

__________/___________ **Months**

Administrative Use Only

Elig. Req. ______/______

Pens. Eff. Date: ________________________

Carrier: ________________________

Eff. Date: ________________________

Log No. ________________________

Initial Billing ________________________