



**CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE FUND**

EMPLOYEE TRUSTEES
 RAY CASH
 JERRY YOUNGER
 GEORGE J. WESTLEY
 CHARLES A. WHOBREY
 FRED GEGARE
EMPLOYER TRUSTEES
 HOWARD McDUGALL
 ARTHUR H. BUNTE, JR.
 TOM J. VENTURA
 DANIEL J. BRUTTO
 GARY F. CALDWELL
EXECUTIVE DIRECTOR
 THOMAS C. NYHAN

RETIREE HEALTH AND WELFARE BENEFIT ELECTION NOTICE

It appears you may be eligible for a Retirement Pension Benefit and the Retiree Health and Welfare Coverage. To obtain the Retiree Health and Welfare Coverage you are required to pay \$50 monthly for this benefit. Before we can finalize your application for a pension benefit, we must know whether you want to have the \$50 per month deducted from your pension check for the Retiree Coverage. Please return this form promptly. We cannot make a final determination on your pension benefit until you have made this election. **To authorize this \$50 deduction, please check Box #1 and answer all related questions, sign and date the form below.**

BOX #1 **I WANT THE RETIREE HEALTH AND WELFARE COVERAGE**

Please direct the Pension Fund to deduct \$50 from my monthly pension checks until I cancel this direction in writing, and to transfer each \$50 deduction to the Health and Welfare Fund as my monthly contribution for Retiree Coverage. I also agree to a retroactive deduction from my pension check to cover the months of Retiree Coverage for which I owe \$50.

I and/or my spouse are currently receiving Social Security Disability Benefits. If covered by Medicare, please submit a copy of your medicare card.

MEMBER YES _____ NO PENDING
entitlement date

SPOUSE YES _____ NO PENDING
entitlement date

I and/or my spouse have "Other Group" Health Coverage or Medicare.

MEMBER YES _____ NO
entitlement date Name of Other Insurance

SPOUSE YES _____ NO
entitlement date Name of Other Insurance

I understand a final determination, as to my eligibility for Retiree Coverage, will be based on my work history and answers to the above questions. My signature below acknowledges my answers to be true and correct.

 SOCIAL SECURITY NUMBER SIGNATURE DATE

If you do not want to receive Retiree Coverage, Check Box #2, sign and date the form below. Please note that a decision to decline Retiree Coverage at this time will make you ineligible to receive Retiree Coverage at any future time for any reason.

BOX #2 **I DO NOT WANT THE RETIREE HEALTH AND WELFARE COVERAGE**

I understand that declining this Retiree Coverage now will make me ineligible to participate at any time in the future.

 SOCIAL SECURITY NUMBER SIGNATURE DATE

Return this form to: Central States Southeast and Southwest Areas
 Health and Welfare and Pension Funds
 P.O. Box 5109
 Des Plaines, IL 60017-5109

If you have any questions, please call toll-free, 1-800-323-5000