WIDOWS ELECTION FORM
MICHIGAN CARPENTERS' HEALTH CARE FUND

I have read and understood the provisions for continuing coverage. I have checked the type of coverage desired below. I understand that, once a type of coverage is elected, it may not be changed at a later date. I also understand that no Death Benefits of any type are provided with COBRA Continuation Coverage.

THIS FORM MUST BE COMPLETED AND RETURNED IN ORDER TO BE ELIGIBLE FOR COVERAGE.

It is the intent of the Board of Trustees to review these rates and make appropriate adjustments on a regular basis.

Are you or any of your dependents currently covered by another group health care plan(s)? ☑ YES ☐ NO

If yes, list names of dependents covered by the other plan(s):_____

If YES, indicate name(s) of plan(s): _____

Are you or any of your dependents currently eligible for Medicare benefits? ☐ YES ☐ NO

I desire to purchase the coverage listed below:

COBRA CONTINUATION COVERAGE (Maximum of 36 months only)

☐ Health Care Benefits & Vision at the rate of **$753.13** per month.

SURVIVING SPOUSE COVERAGE

☐ Widow without Medicare with or without dependents for 1st six months of Health Care & Vision at the rate of **$426.00** per month. Effective with the 7th month and after the rate will be **$728.00** per month.

☐ Widow with Medicare (one person only) for Health Care and Flex Benefits at the rate of **$159.00** per month.

TO INCLUDE DENTAL COVERAGE (FOR SURVIVING SPOUSE AND COBRA COVERAGE), Add an Additional:

☐ - **$21.50** for Single member
☐ - **$51.59** for 2 member family
☐ - **$64.49** for 3+ member family
☐ - **No** I do not want Dental coverage

ALTERNATIVE MINIMUM COVERAGE

☐ In-Patient Benefits, Out-Patient Surgery Benefits at 80%, Diagnostic X-Rays and Laboratory Benefits and Vision **ONLY,** at the rate of **$342.00** per month. NO DENTAL BENEFITS.

DECLINATION OF COVERAGE

☐ I do not desire to purchase either COBRA Continuation Coverage or Surviving Spouse coverage.

_____ _____
Signature of Participant Name of Participant (printed)

_____ _____
Amount Enclosed Date Signed

-OVER-

List individuals to be covered:

Name	Relationship	Date of Birth