ELECTION FORM
MICHIGAN CARPENTERS' HEALTH CARE FUND

W/M _____

I have read and understood the provisions for continuing coverage. I have checked the type of coverage elected below. Should I initially elect Self-Contribution Coverage, I may at a later date change my coverage to Alternative Minimum Coverage by submitting a new Election Form. I also understand that I may **not** revert to Self-Contribution Coverage following election of Alternative Minimum coverage. (It is the intent of the Board of Trustees to review the Self-Contribution and Alternative Minimum Coverage Self-payment coverage rates and make appropriate adjustments on a continuous basis.)

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

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:

SELF-CONTRIBUTION COVERAGE

☐ Health Care, Vision & Dental Benefits at the rate of **$693.00** (140 hours at $4.95 per hour) per month, or amount indicated on enclosed notice.

ALTERNATIVE MINIMUM COVERAGE

☐ In-Patient Benefits, Out-Patient Surgery Benefits, Diagnostic X-Rays and Laboratory Benefits **ONLY,** at the rate of **$342.00** per month, or amount indicated on the enclosed notice. NO DENTAL BENEFITS.

DECLINATION OF COVERAGE

☐ I do not desire to purchase Self-Contribution coverage or Alternative Self-Contribution coverage.

PLEASE SIGN TO CONFIRM ELECTION:

_____ _____ _____
Signature of Participant **Name of Participant (Printed)** **BCBS ID#**

_____ _____
Signature of Spouse **Date**

List individuals to be covered:

Name	Relationship	Date of Birth