SUPPLEMENT TO MEDICARE 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:

SUPPLEMENT TO MEDICARE COVERAGE

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

_☐_Member with Medicare—On Supplement to Medicare Program, spouse (and dependents) without Medicare—On Full Coverage $728 per month

_☐_Member with Medicare—On Supplement to Medicare Program, spouse (and dependents) without Medicare—On Alternative Minimum Coverage $501 per month. (See enclosed Benefits at a Glance for benefits.)[Please note person on Minimum Coverage cannot have dental coverage as indicated below.]

_☐_**To include Dental Benefits add amount indicated below. I understand that my election of dental coverage is a One time election and that I cannot add or cancel dental benefits without writing to the Board of Trustees.**

_☐_**$21.50** for Single member
_☐_**$51.59** for 2 member family
_☐_**$64.49** for 3+ member family
_☐_ **NO** dental benefits

DECLINATION OF COVERAGE

☐ I do not desire to purchase either COBRA Continuation Coverage or Totally & Permanently Disabled coverage.

**************************PLEASE SIGN ON REVERSE SIDE*******************

SUPPLEMENT TO MEDICARE 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 on the reverse side. 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.

Signature of Participant

BCBS ID#

Name of Participant (Please Print)

Date Signed

Amount Enclosed

List individuals to be covered:

Name	Relationship	Date of Birth