SURVIVING DEPENDENTS' 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 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 currently eligible for Medicare benefits? ☐ YES ☐ NO

I desire to purchase the coverage listed below:

COBRA CONTINUATION COVERAGE (Maximum of 36 months only. Not eligible if have any other coverage.)

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

SURVIVING DEPENDENT COVERAGE (**Not eligible if have any other coverage.)**

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

TO INCLUDE DENTAL COVERAGE (FOR SURVIVING DEPENDENT 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

DECLINATION OF COVERAGE

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

_____ _____
Signature of Participant Name of Participant (printed)

_____ _____
Social Security Number Date Signed

_____
Amount Enclosed

List individuals to be covered on reverse:

Name	Relationship	Date of Birth