trust fund office

local union 831

employer health trust fund
employer pension plan

Retiree Benefit Selection Form

I am making the following selection for Retiree Benefits from the Local Union 831 Employer Health Trust Fund:

Please check the coverage you wish to have and for which you are eligible under the Health Plan from the options below:

For Retirees and/or Spouse Not eligible for Medicare

Coverage for: ( ) Retiree ( ) Spouse ( ) Retiree & Spouse ( ) Retiree, Spouse & Dependent(s)

Note: If you **do not** continue medical, dental, and/or vision coverage through the Health Plan, the benefits(s) may no longer be available to you or your dependents for the remainder of the Plan year and all future Plan years. Retiree, Retiree spouse and Retiree dependent eligibility for benefits are governed by the Health Plan document and the Health Plan Trustee's interpretation of the Plan document.

Effective date of Retirement: _____

Retiree Name: _____ Birth date: _____ SS#: _____

Spouse Name: _____ Birth date: _____ SS#: _____

Dependent Name: _____ Birth date: _____ SS#: _____

Home Address: _____

Phone number: _____

*Current Levels of Coverage effective Jan 1, 2017: (**Level 1 - $1288) (Level 2 - $1104) (Level 3 - $920) (Level 4 - $736)**

The Board of Trustees can modify the Cost of Coverage on an annual basis.

I understand that I may be eligible for a subsidy of $15.00 for each Year of Service Credit if I meet the requirements below:

Participate under the Pension Plan on or after January 1, 2007 and (1) have been eligible for Health Plan coverage in twelve of the twenty-four (24) months immediately before retirement; and, (2) have ten (10) years of at least 1,000 hours paid into the Health Plan within fifteen years immediately before retirement, or credited with at least ten (10) full years of Vesting Service in the Southern California Local 831 – Employer Pension Plan within the immediately preceding fifteen (15) years.

I understand that I am responsible to make payment in the full amount due minus any subsidy amount I may be eligible to receive. I must submitted payment to the Administrative office by the 20th of each month prior to the month of coverage. If I do not pay the required premiums in a timely manner, I understand that I can lose my coverage under this Health Plan.

Retiree Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

* Benefits Level rates are subject to changes January of every year.

P.O Box 5528 • El Monte, California 91734
Toll Free 1-877-572-7005 • Phone (626) 279-3080 • Fax (626) 279-3055