Iron Workers District Council of Western New York and Vicinity Welfare Fund

Active Member Self Pay Premiums

These rates are effective as of June 1, 2023, for all Locals who participate in the Welfare Plan. You may select any combination of the Active Member Self Pay options listed below. **Once you have made your selections, you may not add additional levels of coverage at a later date.** You are eligible for the Self Pay option for up to 12 months after your loss of insurance based upon insufficient hours worked in any Work Period. Election of these benefits **MUST** be made and payment received within ten (10) days of your initial termination date. For additional months, payments are due before the first of the subsequent month.

	Life Insurance, AD&D and Supplemental Disability only (employee only)	$31.50 per month
	Single coverage for Medical and Prescription	$609.11 per month
	Single coverage for Medical only **does not include** prescription drug coverage	$491.66 per month
	Single coverage for Dental only	$44.58 per month

	Life Insurance, AD&D and Supplemental Disability (employee only)	$31.50 per month
	Family coverage for Medical and Prescription	$1,576.99 per month
	Family coverage for Medical only **does not include** prescription drug coverage	$1,259.86 per month
	Family coverage for Dental only	$120.38 per month
	Total of the above selection	$

COBRA Premiums

These rates are effective June 1, 2023, for all Locals who participate in the Welfare Plan. COBRA coverage must be elected within 60 days of your termination date.

Note: Neither of the COBRA options offers Life Insurance, Accidental Death & Dismemberment Insurance or Supplemental Disability to the employee, and this benefit cannot be added.

Social Security Disability: If you become disabled before or within the first 60 days of the start of COBRA,you may be entitled to an additional 11 months of COBRA coverage. Contact the Fund Office for moreinformation.

	Single COBRA (Normal)	$682.80 per month
	Family COBRA (Normal)	$1,774.59 per month
	Single COBRA (Core) This coverage does not include Dental or Optical	$651.10 per month
	Family COBRA (Core) This coverage does not include Dental or Optical	$1,688.99 per month
	Total of the above selection	$

I understand that it is my responsibility to make monthly premium payments to the Fund Office, that I will not be billed. Failure to do so will result in termination of my coverage, including any dependents, and that I will not be able to re-enroll into one of these plans. I elect the coverage(s) checked above, and I have enclosed a check made payable to the **Iron Workers District Council** or a completed Supplemental Fund claim form for the amount.

Note: (If electing the "Active Member Self Pay" option), I understand that I must be available for work in the industry (unless retired from the Iron Workers) and that I am not presently employed in any other type of work.

Signature_____ Date_____

Social Security Number: XXX-XX-___ ___ ___ ___ Local Number:_____

_____ I **DO NOT** select any of the above options, and as a result of this, waive my rights to any coverage.