WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN
2730 DAIRY DRIVE SUITE 101
MADISON WI 53718
(608) 276-9111 Phone, (608) 276-9103 Fax or fundoffice@weebf.org

RETIREMENT NOTIFICATION

I, _____ (print name clearly), ID# / SS#_____
do hereby notify the Wisconsin Electrical Employees Health and Welfare Plan (the Fund) that I am at least 55 years of age and I am no longer working in the industry or on the books. **I understand that any credits in my Dollar Bank and Supplemental Unemployment Account (if applicable) will be automatically transferred into my Flexible Benefit Account (Flex Account) and I hereby choose one of the following options:**

OPTION 1:

☐ I wish to start my reduced retiree insurance coverage effective _____.
(must be the beginning of a month)

The retiree coverage includes a life benefit for the retired Policyholder only. The Medical, prescription and life premium amount listed below is based on your current records (Medicare eligible and/or dependents covered) and is subject to change based on your elections below. See attachment B for Retiree premium rates on Medical, prescription and Life benefit only. Reminder: if you remove a dependent this will change the Retiree premium rate, refer to attachment B.

Medical, prescription and Life Benefit _____.

Add in Optional Benefits selected below:_____.

An Early Retiree or Medicare Eligible Retiree may remove a Dependent(s) (not Spouse) from their policy upon electing to make self-payments under this provision. A Spouse can be removed provided proof of other insurance coverage is received. If removing a dependent, please clearly state their names below:

Dependents to be removed from Retiree Plan:_____

Select one of the options related to the optional retiree benefits. IMPORTANT: this is the only time you may elect to enroll in these optional benefits. **If you waive them, you will not have another opportunity to enroll.**

Dental Benefits (check one) ☐ Comprehensive Dental ☐ Preventive Dental ☐ Waive

Vision Benefits (check one) ☐ Vision Benefits ☐ Waive

The current premium for the optional benefits are below:

	Comprehensive Dental	Preventive Dental	Vision
Single	$63.00	$28.00	$14.00
Married	$125.00	$57.00	$27.00
Family	$150.00	$68.00	$32.00

Signature Required on Page 3

OPTION 1 CONTINUED:

Select one of the following options (if applicable) regarding how you will pay your premiums:

☐ I authorize the Fund to deduct my monthly retiree premiums directly from my Flex Account to continue coverage under the Plan.

☐ I do not have a Flex Account; therefore, I will send in the monthly premium payment via check OR by Authorized Agreement for ACH Debit from my account by the 15th of the month prior to the month of coverage.

I understand that at any time I may terminate coverage by submitting a written cancellation request to the Fund Office and complete a UHC Cancellation notice (if applicable). If I submit proof of enrollment in another employer-sponsored group health plan, I will have a one-time opportunity to reinstate Fund coverage (see option 2 for more detail). If I have a Flex Account balance, I will retain access to the balance as long as I maintain account activity (refer to #5 below).

OPTION 2:

☐ I elect to waive my coverage under the Fund effective _____.

(must be the beginning of a month).

I confirm that I (and any eligible Dependents) am (are) enrolled in another employer-sponsored group health plan and that I have provided proof of such coverage to the Fund Office. I understand that by selecting this option I have a one-time opportunity to reinstate coverage in the Fund following termination of coverage under the other employer-sponsored group health plan. To be eligible for reinstatement, I understand that I must submit an enrollment form to the Plan Office within 60 days following termination of coverage under the other group health plan along with proof that I (and eligible Dependents if applicable) were continuously covered under the employer-sponsored group health care plan following the date of this notification.

OPTION 3:

☐ I elect to terminate my coverage under the Fund effective _____.

(must be the beginning of a month).

I understand that to get back into Fund coverage, I must return to work for a Contributing Contractor who submits H&W contributions to the Fund on my behalf, reinstatement to active status will be the month following receipt of 150 hours. I understand I will still have access to my Flex Account balance as long as I maintain account activity, refer to #5 below subject to the Plan's Flex Account forfeiture provisions.

Signature Required on Page 3

I understand that upon <u>continuing coverage with the Fund as a Retiree</u> that ALL of the following will apply:

1. I understand that as a Retiree, my eligible dependents and I will have the medical, prescription drug and any optional benefits elected above but that only I will have the life benefit coverage.
2. I will NOT receive a monthly Retiree premium payment due notice (unless you are running out your Flex Account) and I am aware that I may lose coverage if I do not make my premium payments in timely. I understand that I can sign up for automatic deductions from my checking or savings account at any time or upon depletion of my Flex Account.
3. I MUST enroll in Medicare Parts A and B when I become Medicare eligible. My eligible Dependents MUST also enroll in Medicare Parts A and B when they become Medicare eligible. I MUST provide a copy of the Medicare Card to the Fund Office as proof. Once I (or my dependents) am eligible for Medicare, my/their coverage will be moved to the UnitedHealthcare Group Retiree Advantage Plan upon receipt of the Retiree Notification Form**. I understand that if I wish to terminate coverage, I MUST complete a UHC Cancellation Form and sent to UHC plus send a written notice to the Fund Office within 30 days prior to termination. I understand that if I fail to do so I will be responsible for the premium payments charged to the Fund Office.**
4. My Spouse may Opt-Out of coverage upon completion of the Opt-Out-Form and proof of other insurance coverage. Contact the Fund Office for more information. I understand that only Dependents covered under the Fund at the time of my death will have access to my Flex Account balance. If I have no Dependents covered under the Fund, my Flex Account will be forfeited. I understand I can only file claims for flex reimbursement on myself and those eligible dependents covered under my policy.
5. I understand my Flex Account will be forfeited if there is no account activity (benefits paid from) for five consecutive calendar years OR for accounts holding $400 or less and entire calendar year.
6. I understand that I have a one-time opportunity to elect the optional benefits (page 1) when completing this form. I understand this is my one-time option and I cannot enroll in the optional benefits at a later date.
7. I understand that I can drop the optional benefits at any time without affecting my medical and prescription drug coverage (or the UnitedHealthCare Group Advantage Plan) and understand that I will not be eligible to re-enroll in the optional benefits later.
8. I understand that the coverage level (single, married, family) of any optional benefits I elect will be the same as the coverage level for my medical and prescription drug coverage. For example, if I enroll in family medical, I will be enrolled in family dental and/or vision.

_____ _____

Retire Signature Date

Signature Required on Page 3