ELECTRICAL WORKERS LOCAL 369

BENEFIT AND RETIREMENT FUND
906 MINOMA AVENUE
LOUISVILLE, KY 40217

PHONE:502-635-2611
FAX:502-637-3444
TOLL FREE: 800-427-2495

RETIREE, SURVIVING SPOUSE & DISABLED
Effective January 1, 2010

If you wish to continue coverage under the Electrical Workers Local 369 Benefit Program, please check one of the following:

A. Non – Medicare – Per Adult _____ **Number of Adults**_____
B. Age Eligible Medicare – Per Adult _____ **Number of Adults**_____
C. Disabled Medicare – Per Adult _____ **Number of Adults**_____

Non-Medicare Coverage – Per Adult	$ 359 per month
Medicare Coverage – Per Adult	$ 229 per month
Disability Coverage – Per Adult	$ 218 per month

For rules governing eligibility, please refer to your summary plan description booklet.

Please list the following information about yourself:

Full Name _____ Social Security Number _____

Address _____ City, State, Zip _____

Birth date _____ Phone Number _____

Do you have Medicare? Yes_____ No_____ If yes, effective date _____
If yes, please submit a copy of your Medicare card with this form.
If you have Medicare due to disability, please submit a copy of your Social Service Award.

Please list the following information about your eligible dependent:

Full Name _____ Social Security Number _____

Birth date _____

Does your eligible dependent have Medicare? Yes_____ No_____ Effective Date_____
If yes, please submit a copy of your dependent's Medicare card with this form.
If your dependent has Medicare due to disability, please submit a copy of their Social Security Award.

If you have eligible dependent children, please list their name, social security number and birth date on the back of this form.

If you wish to cancel your coverage under the Plan, please list an effective date, sign and date and return the form to the address above.

Effective date of cancellation_____

Member's Signature _____ Date _____