Plumbing and Pipefitting Industry
Health and Welfare Fund of Kansas

529 South Anna Street, Ste B
Wichita, KS 67209
Phone (316) 264-2339 Fax (630) 230-3913

ELECTING COVERAGE UNDER THE RETIREE BENEFIT PROGRAM OR COBRA

INSTRUCTIONS

Coverage under the Retiree Benefit Program is limited to eligible retirees and, if the retiree elects to participate in the Program, the retiree's spouse. Eligible retirees therefore must choose between the Retiree Benefit Program, coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), or neither.

Please choose between coverage under the Retiree Benefit Program, COBRA, or neither, by marking the appropriate boxes below. After making your choice, please sign and date this Form (spouses of retirees also must sign and date the Form) and return it to the Fund office at the address shown above. Please Note: If married, choosing the Retiree Benefit Program, and not covering the spouse, this form must be signed and notarized, otherwise the notary part can be disregarded.

IMPORTANT!

If a retiree elects to participate in the Retiree Benefit Program now and then decides to return to covered employment in the future, the retiree must re-qualify for coverage as an active employee under the rules of the Plan and *will not be offered the opportunity to participate in the Retiree Benefit Program again*. Thus, the opportunity to participate in the Retiree Benefit Program is available only once.

Payments for Retiree Benefit Program coverage are due at the address above by the 1st day of the month to be covered. For example, a payment for coverage during January must be received by the Fund Office by January 1**.** If you do not pay your premiums in a timely manner or lose coverage under the Retiree Benefit Program for any other reason, *you will not be offered coverage under COBRA unless the retiree returns to covered employment and works the required number of hours to re-qualify for coverage as an active employee*.

Name: _____ **Retiree Benefit Program Election**

☐ **Retiree Benefit Program/Retiree & Spouse.** I elect coverage for myself and my spouse in the Retiree Benefit Program described in the letter which accompanied this Form. Enclosed is my first premium payment in the amount of $600 for coverage beginning _____.

☐ **Retiree Benefit Program/Retiree Only.** I elect coverage for myself only in the Retiree Benefit Program described in the letter which accompanied this Form. Enclosed is my first premium payment in the amount of $300 for coverage beginning _____.

☐ **COBRA.** I wish to elect COBRA coverage from the Plan for myself/spouse and will complete and return my completed COBRA election form to the above address. I may return to covered employment in the future, and therefore wish to preserve my opportunity to elect the Retiree Benefit Program at a later date. *(Please follow the instructions provided in your COBRA packet.)*

☐ **No Coverage.** I am waiving my right to all coverage under the Plan. I understand that I will not have either Retiree Benefit Program coverage or COBRA coverage under the Plan as a result of this election.

_____ _____
Participant's Signature/Date Participant's Name, Please Print

_____ _____
Spouse's Signature/Date Spouse's Name, Please Print

NOTE: The Trustees intend to continue the Retiree Benefit Program, but they reserve the right to cancel or amend this Program and all other benefits offered under the Plan at any time (including, but not limited to, changes to the monthly premium amount).

***Notary only needed if Participant is married and chooses not to cover spouse on Retiree Benefit Program.**

Witnessed by Notary Public

State of _____)
) ss.
County of _____)

On the _____ day of _____, 20____, before me came_____, known to me to be the person described in, and who executed, the foregoing statement, and he/she duly acknowledged to me that he/she executed the same.

_____
Notary Public