



ALASKA TEAMSTER-EMPLOYER WELFARE TRUST

520 E. 34th Avenue, Suite 107

Anchorage, AK 99503-4116

(907) 751-9700 or (800) 478-4450 (Toll Free)

MEDICAL PLAN SELF-PAYMENT BILLING FORM FOR COBRA & MEDICARE ELIGIBLE RETIREES & SPOUSES

1. Personal Information: (Please Print)

R E T I R E E	RETIREE NAME (LAST) (FIRST) (MI)			HICN/SSN
	SPOUSE NAME (LAST) (FIRST) (MI)			HICN/SSN
	DATE OF BIRTH / /	SEX M <input type="checkbox"/> F <input type="checkbox"/>	SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW(ER) <input type="checkbox"/>	TELEPHONE
	MAILING ADDRESS		CITY	STATE ZIP CODE

2. Retiree or Family Coverage Election:

Mark Applicable Coverage: Medicare Retiree Health Care (RHC) COBRA COBRA & RHC

▶ *If you are presently Medicare eligible, you can elect COBRA and/or the Retiree Health Care coverage. In addition, the COBRA coverage would also be for Non-Medicare Eligible Spouses under age 65 and Children.*

(Choose one box only): I select **COBRA** coverage for the following members of my family:

- Retiree Only* Retiree & Spouse Retiree, Spouse & Children Retiree & Children
 Spouse (or) Surviving Spouse Spouse & Child(ren) (or) Surviving Spouse & Child(ren)

* I am aware that I am waiving **COBRA** coverage for my spouse and/or dependent children. _____
Signature of Retiree or N/A if no dependents

3. TEAMStar Retiree Health Care (RHC) Benefit Coverage Election.

(TEAMStar RHC coverage for Medicare Eligible Retirees and/or Medicare Eligible Spouses only.)

***** Please attach a copy of your MEDICARE ID Card(s) to this form. *****

- (Check applicable boxes): Medical & Prescription Drug Benefit - \$323 Medical Only - \$200
 Prescription Drug Benefit Only - \$123 Retiree Life Insurance Benefit (for retirees only) - \$30

(Choose one box only): This **TEAMStar** Retiree Health Care (RHC) Benefit Coverage is for:

- Retiree Only* Retiree & Spouse Surviving Spouse

* I am aware that I am waiving **TEAMStar** coverage for my spouse. _____
Signature of Retiree or N/A if no dependents

***** Continued on next page *****

4. Authorization for Automatic Deduction:

I authorize the deduction of the monthly medical plan self-payment from my pension benefit check if it is sufficient to cover the *entire* self-payment amount. I further authorize the deduction from my pension benefit check of any overpayment that I receive in error from the Welfare Trust which I do not promptly repay after I receive a written notice of the error and a request for refund. I understand that I may revoke these authorizations for automatic deduction at any time by written notice to the Welfare Trust at the address shown above.

YES

NO

I understand self-payment amounts are reviewed on an annual basis and are contingent on the cost to provide health care coverage. I further understand these self-payment amounts may be subject to change based on those annual reviews.

Signature

Date

**** Please complete a new form if you need to change any information from your previous form.**

For additional information regarding the *TEAMStar* Plan Benefits, please go online to:

TEAMStar Supplemental Medical (www.teamstar.com)

TEAMStar Medicare Part D (www.teamstarpartd.com)

Office use only: _____ ATEPT deduction stopped _____ ACH stopped _____ Change form sent to Benesys