Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Ave. Detroit, MI 48216
Phone: 313-964-2400. Fax: 313-964-3144. Email: RetireeDept@mctwf.org MCTWF

Retirees Plan Enrollment Application

Participant's Section		
Participant's Name (Last – First – Middle)	Contract Number __ __ __ __ __ __ __ __ __	
Address	Phone Number ( ) -	Date of Birth __ __/__ __/__ __
	Last Date Worked __ __/__ __/__ __ **or** Anticipated Last Date Worked __ __/__ __/__ __	Total No. Years in MCTWF
City State Zip	Eligible for Medicare? ☐ Yes ☐ No	Medicare Effective Date __ __/__ __/__ __
I understand that if I have or become eligible for Medicare Part A and/or B, I am no longer eligible to participate in a MCTWF Retirees benefit package. I will notify MCTWF immediately upon my notification of early Medicare coverage. Participant's Signature_____ Date _____		

Below please list all the employers for whom you were employed under a Teamster collective bargaining agreement. Please attach a supplemental list for additional employers, and include any subsequent name changes for those employers.

Name of Employer	Location (City – State)	From (MM/YY)	To (MM/YY)
1.			
2.			
3.			
4.			
5.			
6.			

Spouse's Section		
Spouse's Name (Last – First – Middle)	Social Security Number __ __ __ __ __ __ __ __ __	Date of Birth __ __/__ __/__ __
Address	Phone Number ( ) -	
	Eligible for Medicare? ☐ Yes ☐ No	Medicare Effective Date __ __/__ __/__ __
City State Zip		
I understand that if I have or become eligible for Medicare Part A and/or B, I am no longer eligible to participate in in a MCTWF Retirees benefit package. I will notify MCTWF immediately upon my notification of early Medicare coverage. Spouse's Signature_____ Date _____		

Please determine my eligibility for the MCTWF Retirees Plan	
Retiree's Signature	Date

To expedite your enrollment please fill out the reverse side of this form.

So that MCTWF may expedite your enrollment into the MCTWF Retirees Plan please answer the below and sign –

- Can MCTWF contact your current employer to determine through what date its last health and welfare contributions will be paid on your behalf?

  ☐ Yes, MCTWF may contact my employer to determine through what date its last contributions will be paid on my behalf.

  ☐ No, MCTWF may not contact my employer to determine through what date its last contributions will be made on my behalf. I understand that if MCTWF is not authorized to contact my employer, MCTWF will assume that the last health and welfare contributions paid on my behalf will be for the week of my last date worked or my anticipated last date worked (as stated on the front of this form).

- Assuming that your *Application* for enrollment in the MCTWF Retirees Plan is approved, do you decline your COBRA continuation coverage rights to which you otherwise will become entitled upon your retirement? Please note that you nonetheless will receive a COBRA notification offering COBRA continuation coverage upon notification by your employer of your cessation of employment. Upon your receipt of the COBRA notification, you will still have 60 days to elect COBRA continuation coverage and defer MCTWF Retirees Plan enrollment.

  ☐ Yes, assuming that my *Application* for enrollment is approved, I decline my COBRA continuation coverage rights.

  ☐ No, I do not want to decline my COBRA continuation coverage rights at this time.

Assuming that your *Application* for enrollment under the MCTWF Retirees Plan is approved, do you wish to immediately defer your coverage under the MCTWF Retirees Plan?

☐ Yes, assuming that my *Application* for enrollment is approved, I would like to immediately defer my coverage under the MCTWF Retirees Plan. I understand that at such time that I seek to commence participation, I must notify MCTWF and that the self-contribution rate will be calculated based upon my age at the commencement of coverage.

☐ No, I do not wish to defer my coverage under the MCTWF Retirees Plan at this time.

Retiree's Signature _____ Date _____

This *Application* must be received by MCTWF within 90 days immediately following your Retirement Date. If the completed *Application* is received beyond the 90 window period, but within one year of the Retirement Date, coverage will commence as of the first day of the month that falls at least 90 days after MCTWF's receipt (and subsequent approval) of this *Application*. Your Retirement Date is the date upon which you last were covered under a MCTWF active or COBRA plan of benefits that provides for MCTWF Retirees Plan **eligibility.**

Important: To be eligible for MCTWF Retirees Plan **coverage the retiree and/or the retiree's spouse must not be eligible for Medicare coverage.**