

**UPPER PENINSULA PLUMBERS' & PIPEFITTERS' HEALTH & WELFARE FUND**

**ELECTION FORM**

I have read and I understand the provisions for continuing coverage. I have checked the elected coverage below. I understand that, once a type of coverage is elected, it may not be changed at a later date. I also understand that no Death Benefits of any kind are provided by either type of COBRA CONTINUATION COVERAGE.

**\*\*The rates listed below will be in effect as of February 1, 2005\*\***

**Please answer the following questions:**

1. Are you or any of your dependents currently covered by any other group health care plan?  
YES \_\_\_\_\_ NO \_\_\_\_\_
2. If YES to Question 1, list name(s) of dependent(s) covered by other plan(s): \_\_\_\_\_  
\_\_\_\_\_
3. If YES to Question 1, indicate name of plan(s): \_\_\_\_\_
4. Are you or your dependent(s) currently eligible for Medicare benefits? YES \_\_\_ NO \_\_\_
5. Are you currently working for an employer who is delinquent in paying fringe benefit contributions? YES \_\_\_\_\_ NO \_\_\_\_\_
6. If YES to Question 5, **you are NOT eligible to remit ALTERNATIVE COVERAGE self-payments.**

**Please elect one of the following types of coverage:**

**COBRA CONTINUATION COVERAGE AS CHECKED BELOW:**

\_\_\_\_\_ Health Care Benefits ONLY, at the rate of **\$806.00** per month for 18 consecutive months when loss of coverage results from unemployment or failure of employer to remit fringe benefit contributions (excludes Death Benefits).

**ALTERNATIVE COVERAGE AS CHECKED BELOW:**

\_\_\_\_\_ Health Care Benefits ONLY, at **\$685.00** per month.

(continued on reverse side)

**Please complete the following:**

\_\_\_\_\_  
Name of Participant (Please type or print)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Spouse (If applicable)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Amount Enclosed

\_\_\_\_\_

\_\_\_\_\_

**Please list individuals to be covered:**

Name

Relationship

Date of Birth

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