

**NECA-IBEW WELFARE TRUST FUND**  
**SUPPLEMENTAL (RETIREE) RETIREMENT PROGRAM PARTICIPATION FORM**

2120 Hubbard Avenue, Decatur, IL 62526-2871~ (217) 875-0254

**READ RULES ON REVERSE SIDE OF THIS FORM BEFORE COMPLETING.**

Retiree's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
\_\_\_\_\_  
( ) \_\_\_\_\_  
Soc. Sec. No. \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Section 1: Application (Complete only if ELECTING coverage)**

**Effective date** (please fill in date): \_\_\_\_\_ 1, 20\_\_\_\_\_  
Month Year

**Do you want Spousal coverage:**  No  Yes *Please complete the following information.*

Does Spouse have  
other coverage or Medicare?

Spouse's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Birth Date \_\_\_\_\_  No  Yes

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: Retiree In-and-Out Program Participation (Complete only if WAIVING coverage)**

I/We choose to waive coverage under the NECA-IBEW Welfare Trust Fund Supplemental Retirement Program effective ***when my bank hours terminate***. I/We have read and understand the rules regarding opting out of the retiree coverage and understand that this is a one-time election and that I/we must provide proof of continuous health coverage when I/we return to the Plan.

Member's Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

(over)

## Rules Regarding Waiving Retiree Coverage

The Fund will allow you the opportunity to delay participation in the Plan if you have other medical coverage available through your spouse's employer. Under the provisions of the In-and-Out Program, you and your spouse may postpone coverage, maintaining your eligibility to participate in this Plan, until you are no longer eligible for coverage under another plan.

To waive coverage and delay participation in the Retiree Program until a future date, you must:

- ❖ file this written notice of a decision to delay coverage with the Fund Office within 30 days immediately following the date you first become eligible for retiree coverage; and
- ❖ be covered under another health plan.

The decision to delay coverage and reserve the right to apply for coverage at a later date is a one-time only option. If you choose not to opt out of retiree coverage at the time of retirement, you will not be given another opportunity at a later date. Also, once you are covered under the Retiree Program, you will not be allowed to opt out and resume coverage a second time.

Once your other coverage ends, you must:

- ❖ file a written application with the Fund Office within 30 days following the date your other coverage ends;
- ❖ provide proof that you were continuously covered by your spouse's plan since the date you elected to delay your coverage under this Plan; and
- ❖ make the required self-payment contribution for coverage.

The NECA-IBEW Welfare Trust Fund will deny re-entry into the Plan if you fail to provide proof of continuous health coverage.