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)

RETIREE	RETIREE NAME (LAST) (FIRST) (MI)			MEDICARE BENEFICIARY IDENTIFIER (MBI)
	SPOUSE NAME (LAST) (FIRST) (MI)		DOB	MEDICARE BENEFICIARY IDENTIFIER (MBI)
	DATE OF BIRTH / /	SEX M ☐ F ☐	SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOW(ER) ☐	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. TEAM*Star* 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 - $388.24** ☐ **Medical Only - $239**

☐ **Prescription Drug Benefit Only - $149.24** ☐ **Retiree Life Insurance Benefit (*for retirees only*) - $30**

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

☐ **Retiree Only*** ☐ **Retiree & Spouse** ☐ **Surviving Spouse**

* I am aware that I am waiving **TEAM*Star*** 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