



# ALASKA TEAMSTER-EMPLOYER WELFARE TRUST

520 E. 34<sup>th</sup> 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)			MEDICARE BENEFICIARY IDENTIFIER (MBI)
	SPOUSE NAME (LAST) (FIRST) (MI)		DOB	MEDICARE BENEFICIARY IDENTIFIER (MBI)
	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 - \$414.24  Medical Only - \$265.00  
 Prescription Drug Benefit Only - \$149.24  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](http://www.teamstar.com))

*TEAMStar* Medicare Part D ([www.teamstarpartd.com](http://www.teamstarpartd.com))

*Office use only:*      \_\_\_\_\_ ATEPT deduction stopped      \_\_\_\_\_ ACH stopped      \_\_\_\_\_ Change form sent to Benesys