MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200
BURLINGTON, MASSACHUSETTS 01803-5201
TELEPHONE (781) 272-1000 FAX (781) 238-0703 800-342-3792

SELF-PAY
RETIREES MEDICAL PROGRAM ELECTION FORM

All information on this form must be completed by each person to continue coverage and returned to the Fund Office with your check, within 30 days of receipt.

Are you presently ON/OR filed for Medicare or other Health Insurance? _____Yes _____No

Is your spouse ON/OR filed for Medicare, or other Health Insurance? _____Yes _____No

If yes - please identify the name of Insurance Carrier. _____

_____

IF YOU ARE CURRENTLY ELIGIBLE FOR MEDICARE OR ANY OTHER HEALTH INSURANCE PROGRAM, YOU ARE NOT ELIGIBLE FOR THE SELF-PAY PROGRAM.

Type of Coverage: (Check One Only)

	Individual		Family	
	Plan A	Plan B	Plan A	Plan B
Plan I-CORE: Medical, Surgical, Hospital, Hearing and Prescription Benefit	_____	_____	_____	_____
Plan II- NON - CORE: All of the above plus Dental	_____	_____	_____	_____

Members Name: _____ Local Union #:_____
(Please Print)

Soc. Sec. #: _____ Date of Birth:_____

Spouse's Name: _____
(Please Print)

Soc. Sec. #: _____ Date of Birth:_____

Address: (Premium notice will be sent to this address) Tel. # ( )_____-_____

Street _____

City/Town, Zip _____

Signature of Member _____ Date: _____

Signature of Spouse _____ Date: _____

Name: _____ (Last) _____ (First)