MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

PO BOX 1501 • 1400 DISTRICT AVENUE • SUITE 200
BURLINGTON, MASSACHUSETTS 01803-1501
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

SELF-PAY
RETIREES MEDICAL PROGRAM ELECTION FORM

All information on this form must be completed by each person electing 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**	**2 Person**	**Family**
	Plan B	**Plan B**	**Plan B**
Plan I-CORE Medical, Surgical, Hospital, Hearing and Prescription Benefit	_____	_____	_____
Plan II-CORE and DENTAL All of the above plus Dental	_____	_____	_____

Member's Name: _____ Local Union #: _____
(Please Print) (Last) (First)

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, State, Zip Code: _____

Signature of Member: _____ Date: _____

Signature of Spouse: _____ Date: _____

****INCOMPLETE FORMS WILL BE RETURNED****