

OPERATING ENGINEERS HEALTH & WELFARE FUND

**ELECTION FORM FOR SELF-PAYMENT OF
RETIREE HEALTH & WELFARE FEE**

(PLEASE PRINT)

PENSIONER'S NAME _____
Last Name First Name Initial

PENSIONER'S ADDRESS _____
Street

City State Zip Code

PENSIONER'S SOCIAL SECURITY NUMBER _____

COMMENCEMENT MONTH OF COVERAGE _____

AMOUNT OF QUARTERLY PAYMENT DUE _____

In order to satisfy the requirements for eligibility for Retiree Plan Benefits under the Operating Engineers Health and Welfare Fund, I hereby elect to make direct payment to the Fund Office. I understand that such payments will cover three months of coverage and that the Quarterly payments must be received by the Fund Office prior to the first day of the Calendar Quarter for which eligibility is desired, OTHERWISE BENEFITS WILL BE TERMINATED.

After the initial enrollment period, I understand I may discontinue payments at any time, and I will not be entitled to re-enter the Plan until the open enrollment period during the month of December for benefits starting the following April 1.

Date

Signature of Pensioner