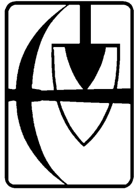

Laborers Pension Trust Fund for Northern California
Laborers Health and Welfare Trust Fund for Northern California
5672 Stoneridge Drive, Suite 100 ◆ Pleasanton, CA 94588
Telephone: (707) 864-2800 ◆ Toll-free: (800) 244-4530

Authorization / Election

Please read all four options below. Choose one and check-off the appropriate box.

☐ ***ENROLL IN RETIRED PLAN****: I hereby authorize the Board of Trustees of the Laborers Pension Trust Fund for Northern California to deduct the appropriate monthly charge from my monthly pension check for participation in the Retired Laborers Health and Welfare Plan which I have elected. I enclose the completed Retired Plan Benefit Application Form. I understand that I may cancel this authorization at any time by providing the Fund Office written notice* ***60 days in advance*** *of the first day of the month I want coverage to terminate.*

☐ ***WITHDRAWAL FROM RETIRED PLAN****: I do not wish to participate in the Retired Laborers Health and Welfare Plan.* ***I UNDERSTAND THAT I MAY NOT BE GIVEN THE OPPORTUNITY TO ELECT RETIRED LABORERS HEALTH AND WELFARE COVERAGE AGAIN****. You should be aware that if you are married and elect the "Joint-and-Survivor Pension" Pension form of payment but you elect not to participate in the Health and Welfare Plan, your surviving spouse will not be eligible to participate in that Plan following your death.*

☐ ***CONTINUE ACTIVE COVERAGE THROUGH COBRA****: I wish to continue participating in the Active COBRA Laborers Health and Welfare Plan at this time, and hereby authorize the Board of Trustees of the Laborers Pension Trust Fund for Northern California to deduct the appropriate monthly charge from my monthly pension check. I reserve the right to participate in the Retired Laborers Health and Welfare Plan at a later time and understand that I must provide a written authorization to the Fund Office* ***within 30 days*** *from the date the Active COBRA Plan expires.*

☐ ***ENROLLMENT DEFERRAL****: I wish to defer enrollment in the Retired Laborers Health and Welfare Plan at this time because I have other health coverage or a health insurance policy or program, including COBRA Continuation Coverage, individual insurance, Medicaid or other public program, other than Medicare (****please attach a copy of proof of coverage****). To reestablish my eligibility, I understand that I must enroll in the Retired Laborers Health and Welfare Plan* ***within 60 days*** *after termination of my other coverage and I must provide the Fund proof of termination of other health coverage.*

______________________________	______________________________
Retiree's Signature	**Date Signed**
______________________________	______________________________
PRINT Name	**Social Security Number**