

**IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST  
 IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY PENSION TRUST  
 MAIN P.O. BOX 398 DAYTON, OHIO 45401  
 (937) 454-1744 (800) 331-4277**

Date \_\_\_\_\_

If you have been eligible for insurance benefits for 36 out of the last 60 months prior to the date of your retirement, you are eligible to participate in the self-pay program for retirees. Please check with the fund office to see if you are qualified. If you are qualified and would like to participate, please fill out this application and return it to us as soon as possible.

I wish to adopt the following payment schedule on my Retiree Pay Direct premium for Health Insurance Benefits:

_____ Retiree and Family	Payment amt	<u>\$400.00 each adult + \$50.00 each child</u>
_____ Retiree only/Spouse only Widow or Widower only	Payment amt	<u>\$400.00</u>
_____ Widow /Widower/Spouse and Children	Payment amt	<u>\$400.00 + \$50.00 each child</u>
_____ Children only	Payment amt	<u>\$50.00 each child</u>
_____ Medicare Supplemental	Payment amt	<u>\$150.00 per person</u>

THIS PLAN DOES NOT COVER VISION OR DENTAL OR HEARING AIDS.

**If you wish to pay the premium by check, complete Part A. If you want your benefit payment made from your pension check, complete Part B.**

PART A: I understand my check is due before the first day of each month and that if not paid in a timely fashion, my insurance will be terminated without notice and I will not be permitted to resume self-payments for any reason.

SS# \_\_\_\_\_ 1<sup>ST</sup> payment due: \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Signature

PLEASE DATE AND RETURN WITH YOUR 1<sup>ST</sup> CHECK TO THIS OFFICE.  
 A coupon book will be issued for your convenience in making payments.

PART B: Until further notice, you are directed to pay to the Benefit Trust so much of my monthly Pension payment as needed to cover my premiums for health care coverage. This direction is revocable at any time by me.

\_\_\_\_\_ Date \_\_\_\_\_ Social Security Number

\_\_\_\_\_ Printed Name \_\_\_\_\_ Signature

**PREMIUMS WILL NOT BE DEDUCTED UNTIL WE HAVE YOUR SIGNED AUTHORIZATION !!!**

Termination date for active insurance: \_\_\_\_\_  
 Activation date for retiree insurance: \_\_\_\_\_  
 Deducted from pension starting: \_\_\_\_\_

Payment amounts and dates are based on information available at this time. **Reminder:** When you become eligible for Medicare, you will automatically be enrolled in Part A (Hospital Benefits) and Part B (Physician Benefits). Although you will be given the option by Medicare to opt out of Part B, the Fund will only pay claims secondary to what Medicare Part B would pay whether you are enrolled or not. You will be held responsible for any overpayment incurred by the Plan if you opt out of Medicare Part B.