THE UMWA Health and Retirement FUNDS

APPLICATION FOR HEALTH BENEFITS

ALL APPLICATIONS FOR HEALTH BENEFITS SHOULD BE SENT TO:

UMWA Health and Retirement Funds
2121 K Street, NW
Suite 350
Washington, DC 20037-1879
1-800-291-1425
Fax: 202-521-2353
E-mail: Pension@umwafunds.org

THE UMWA Health and Retirement FUNDS

HEALTH BENEFITS APPLICATION

GENERAL INFORMATION—Use this form to apply for Funds health benefits coverage. If your application is approved, the Funds will issue you a health services card identifying you and your eligible dependents as Funds' beneficiaries. **Please remember that you are responsible for notifying the Funds of any changes in your circumstances that may affect your eligibility or your dependents' eligibility for health benefits.**

ELIGIBILITY FOR RETIRED OR DISABLED MINE WORKERS—If you fit into any of the following categories, you **may** be eligible for Funds health benefits:

- Retired and disabled mine workers who are receiving 1950 Pension Plan pensions, unless they are receiving a Partial Pension and used non-classified (supervisory) service to meet the minimum vesting requirements.
- Certain disabled mine workers who are not eligible for pensions from the Funds.
- Certain retired and disabled mine workers who are receiving 1974 Pension Plan pensions (see note below).

Note: In general, 1974 Pension Plan pensioners and their dependents and survivors will be eligible for health benefits from the Funds only if the last signatory coal company that employed the mine workers was a participating employer, and only if that company has been determined by the Funds Trustees to be out of business and financially unable to provide the health benefits.

ELIGIBILITY OF DEPENDENTS OF RETIRED OR DISABLED MINE WORKERS—If you are eligible for Funds health benefits, the following individuals may be eligible for benefits as your dependents:

- A spouse who is living with you or being supported by you.
- Unmarried children under the age of 22 if they are supported by you.
- Disabled or mentally retarded children of any age if they are living with you or if they are confined to an institution for care and treatment. If such a child is age 22 or older, the disability must have begun before the age of 22 and must have remained continuous. A physician must provide documentation to substantiate the dependent's inability to live and function independently.
- Unmarried grandchildren under the age of 22 if they live with you and are supported by you.
- Parents and parents-in-law if they have lived with you and been supported by you continuously for a period of at least one year.

Note: In general, you are considered to support a dependent if you provide over one-half of the dependent's total support on a regular basis. However, a spouse who is living with you is presumed to be your dependent, regardless of the amount of support that you provide. For children who are full-time students, earnings and scholarships are not considered when determining the amount of support. When determining the amount of support for separated spouses, grandchildren, parents and parents-in-law, income from all sources is considered, including Social Security, Black Lung benefits, pensions and employment.

SURVIVING SPOUSE OF A DECEASED MINE WORKER—In general, unmarried surviving spouses are eligible for Funds health benefits if the deceased mineworker was eligible for Funds pension and health benefits at the time of death, or if he was killed in a mine accident while employed in a classified job for a signatory employer. If you fit into any of the following categories you **may** be eligible for Funds health benefits.

- Widows of deceased mineworkers who were receiving 1950 Pension Plan pensions at the time of death.
- Surviving spouses of certain deceased mineworkers, who were receiving 1974 Pension Plan pensions at the time of death.
- Surviving spouses of certain mineworkers who were killed in mine accidents while they were employed in classified jobs for signatory employers.

ELIGIBILITY OF DEPENDENTS OF SURVIVING SPOUSES

If you are the surviving spouse and you are eligible for Funds health benefits, the following individuals may be eligible for benefits as your dependents:

- Unmarried surviving children under the age of 22, if they are supported by you.
- Disabled or mentally retarded surviving children of any age if they are living with you or if they are confined to an institution for care and treatment. If such a child is over the age of 22, the disability must have begun before the age of 22 and must have remained continuous. A physician must provide documentation to substantiate the dependent's inability to live and function independently.

If there is no surviving spouse but there are surviving unmarried dependent children, the children may be eligible for Funds Health Benefits in the following cases:

- If the deceased mine worker was eligible for Funds pension and health benefits at the time of death, the surviving children may be eligible until they reach the age of 22 or for 22 months after the month in which the mineworker died, whichever comes first.
- If the deceased mine worker was killed in a mining accident while employed in a classified job for a signatory employer, the surviving children may be eligible until they reach the age of 22.

EARNINGS LIMITATION—An earnings limitation applies to Funds health services cardholders who are eligible for benefits from the 1992 Benefit Plan and the Combined Benefit Fund. In general, health benefits will not be provided during any month in which a beneficiary is regularly employed at an earnings rate equivalent to at least $1,000 per month. This limitation applies to retired and disabled mineworkers, surviving spouses, and surviving dependent children (except for full-time students).

If your pension effective date is after October 1, 1994, there is no earnings limitation for health benefits as of December 19, 2006, under the 1993 Benefit Plan.

IMPORTANT MEDICARE ENROLLMENT INFORMATION—There are several types of Medicare coverage, including Part A (Hospital Insurance) and Part B (Medical Insurance). The health plans administered by the Funds require that you enroll in Medicare Part B as soon as you become eligible to receive Medicare benefits. Failure to enroll in Medicare may delay or result in the suspension of your health benefits coverage from the Funds. If you are not currently receiving Medicare benefits but become eligible at a later date, please contact our office immediately.

When you become eligible for Medicare, the Funds may use the information you provide on this application to enroll you in the Funds' Medicare health plan. The Funds' Medicare plan provides the same benefits as the Original Medicare program. However, we will give you at least thirty (30) calendar days to tell us in writing that you do not wish to be enrolled in the Funds' Medicare plan. Your benefits from the Funds will not be affected if you choose to opt-out of the Funds' Medicare plan. If, however, you decide to opt-out, the Funds will receive less money from Medicare and, because your medical claims will be processed first by Medicare and then the Funds, your medical claims may take longer to be processed. A Summary of Benefits describing your Funds health benefits will be mailed upon the approval of your health benefits. If you have questions concerning Medicare, please call 1-800-MEDICARE.

Health Services Card Application Checklist

All applicants must remember to:

- ☐ **Attach birth certificates for each dependent.**
- ☐ **Attach marriage certificate.**
- ☐ **Complete all pages of this application.**
- ☐ **Each applicant (including dependent children) must sign the Medicare Authorization form even if they are not currently eligible for Medicare.**
- ☐ **For adopted children, please provide a copy of the Adoption Decree or related documents.**
- ☐ **Sign the application when complete.**

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Health Services Card Application

Information about the Mine Worker

NAME (LAST, FIRST, MIDDLE)			SOCIAL SECURITY NUMBER
ADDRESS			TELEPHONE NUMBER & AREA CODE ( )
CITY	STATE	ZIP	DATE OF BIRTH
E-MAIL ADDRESS:	ALTERNATE TELEPHONE #		

If Mine Worker is deceased, complete section entitled "Information About Deceased Mine Worker."

Information about the Applicant if other than Mine Worker

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH:	SOCIAL SECURITY NUMBER
ADDRESS		TELEPHONE NUMBER & AREA CODE ( )
CITY	STATE ZIP	ARE YOU CURRENTLY ENROLLED IN MEDICARE? ❑ YES ❑ NO
E-MAIL ADDRESS:	ALTERNATE TELEPHONE # ( )	ARE YOU CURRENTLY EMPLOYED? ❑ YES ❑ NO

Information About the Mine Worker's Spouse

NAME (LAST, FIRST, MIDDLE)		AREA CODE & TELEPHONE NUMBER
ADDRESS	CITY	STATE ZIP
SOCIAL SECURITY NUMBER	DATE OF MARRIAGE (Attach copy of your marriage certif.)	DATE OF BIRTH (Attach a copy of birth certif.)

Dependents of Applicant

NAME OF DEPENDENT	RELATIONSHIP TO APPLICANT	DATE OF BIRTH (Attach a copy of birth certificate)	DOES DEPENDENT LIVE IN YOUR HOME YES / NO	DO YOU PROVIDE 50% OF SUPPORT YES / NO	MONTHLY EARNINGS	SOCIAL SECURITY NUMBER

Give the names of any dependents listed above who are enrolled in Medicare. Give the names of any dependents who are working or are full time students.

Enrolled in Medicare _____ _____

Name Relationship

Working _____ _____

Name Employer

Currently Fulltime Student _____ _____

Student Name Student Name

_____ _____

School School

Last Coal Industry Employment *(Complete this section only if you are a 1974 Plan pensioner.)*

NAME OF **LAST** COAL INDUSTRY EMPLOYER (INCLUDE NON-UNION EMPLOYMENT)	MINE NAME OR NUMBER
LOCATION OF MINE	LOCAL UNION NUMBER
YOUR LAST JOB CLASSIFICATION	LAST DAY WORKED

DID THE LAST SIGNATORY EMPLOYER PROVIDE HEALTH BENEFITS? ❑ YES ❑ NO IF YES, WHEN DID HEALTH BENEFITS END?

Information About a Deceased Mine Worker

(Complete this section only if you are applying for benefits as the surviving spouse of a deceased mine worker.)

WERE YOU MARRIED TO THE MINE WORKER AT THE TIME OF DEATH?	❑ YES	❑ NO
WERE YOU LIVING WITH THE MINE WORKER AT THE TIME OF DEATH?	❑ YES	❑ NO

DATE OF MINE WORKER'S DEATH	DATE OF MARRIAGE

HAVE YOU REMARRIED SINCE THE MINE WORKER'S DEATH?	❑ YES	❑ NO
IF "YES," GIVE THE DATE OF REMARRIAGE:		
WAS THE MINE WORKER KILLED IN A MINE ACCIDENT?	❑ YES	❑ NO

IF "YES," GIVE THE FOLLOWING INFORMATION:

NAME OF COAL COMPANY	DATE OF MINE ACCIDENT

NAME OF MINE WHERE ACCIDENT OCCURRED

MINE WORKER'S JOB CLASSIFICATION AT THE TIME OF THE ACCIDENT

Please be sure to sign below to avoid unnecessary processing delays. Continue to complete all remaining sections of the application that apply to you.

Applicant's Certification

I certify that all of the information on this application is true and correct. I understand that if any of the information is false, and that if I then receive benefits because of false information, I shall have to repay the benefits to the Funds. I also understand that if I have deliberately given false information, the Funds may take legal action against me.

APPLICANT'S SIGNATURE **DATE**

The application must be signed above by the Pensioner, if living, or the Surviving Spouse. Thank you.

Veterans Benefits

HAVE YOU OR ANY OF THE DEPENDENTS LISTED ON THIS APPLICATION EVER BEEN IN THE MILITARY SERVICE? ❑ YES ❑ NO

IF YES, ARE YOU OR ANY OF THE DEPENDENTS ELIGIBLE FOR VA DISABILITY HEALTH BENEFITS? ❑ YES ❑ NO

IF YES, IS YOUR DISABILITY ❑ FULL ❑ PARTIAL

Current Employment

(Complete this section only if you have worked since your pension effective date.)

EMPLOYER'S NAME			DATE EMPLOYMENT BEGAN
EMPLOYER'S ADDRESS			DATE EMPLOYMENT TERMINATED*
CITY	STATE	ZIP	MONTHLY EARNINGS (GROSS)
EMPLOYER'S TELEPHONE NUMBER & AREA CODE			YOUR JOB TITLE/TYPE OF WORK

***Please attach a statement from your employer verifying the date that your employment terminated.**

Health Insurance Information

DO YOU HAVE GROUP HEALTH INSURANCE **OTHER THAN MEDICARE** FROM ANY ORGANIZATION OTHER THAN THE FUNDS? ❑ YES ❑ NO

IF "YES," GIVE THE FOLLOWING INFORMATION:

NAME OF ORGANIZATION PROVIDING THE COVERAGE

GROUP POLICY NUMBER

ADDRESS OF INSURANCE COMPANY

CITY STATE ZIP

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Authorization to Obtain Medicare Information

Mineworker Name (Last, First, Middle)		Social Security Number:
Claim Number	Hospital Insurance Effective Date	Medical Insurance Effective Date

Spouse or Other Dependent Name (Last, First, Middle)		Social Security Number:
Claim Number	Hospital Insurance Effective Date	Medical Insurance Effective Date

Dependent Name (Last, First, Middle)		Social Security Number:
Claim Number	Hospital Insurance Effective Date	Medical Insurance Effective Date

Dependent Name (Last, First, Middle)		Social Security Number:
Claim Number	Hospital Insurance Effective Date	Medical Insurance Effective Date

Dependent Name (Last, First, Middle)		Social Security Number:
Claim Number	Hospital Insurance Effective Date	Medical Insurance Effective Date

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that the Funds' Medicare plan will release my information (including any prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this form and 2) documents of this authority are available upon request.

Mineworker Signature _____ Date: _____

Spouse/Dependent Signature _____ Date: _____

Dependent Signature _____ Date: _____

Dependent Signature _____ Date: _____

Dependent Signature _____ Date: _____

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