

**ST. LOUIS GRAPHIC ARTS JOINT HEALTH & WELFARE FUND**  
**Selection of Medicare Retiree Medical Coverage**

**NOTICE:** If you desire to continue health coverage for yourself, your spouse, and/or your dependent children, this form must be received by the Fund Office within 60 days from the termination date shown on the attached Notice of Termination; forms received late will not be accepted. In order to avoid any interruption in coverage, attach a check made payable to the St. Louis Graphic Arts Joint Health & Welfare Fund for the first month's cost.

Please fill in below:

Participant Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**PERSONS ELECTING MEDICARE RETIREE MEDICAL COVERAGE:**

	<u>Name</u>	<u>Birth Date</u>	<u>Soc. Sec. No.</u>
Participant:	_____	_____	_____
Spouse:	_____	_____	_____
Dependent:	_____	_____	_____
Dependent:	_____	_____	_____
Dependent:	_____	_____	_____

Place an "X" before the coverage elected. All individuals covered by this election must be covered under the same plan. THE SELECTION YOU MAKE MAY NOT BE CHANGED AFTER THE 60 DAY ELECTION PERIOD.

**Open Access III Medicare**

- Retiree covered by Medicare .....\$230.24
- Retiree with Spouse both covered by Medicare..... \$460.48
- Retiree with Spouse and Dependent all covered by Medicare..... \$690.62

**Medicare Complete**

- Retiree covered by Medicare .....\$20.00
- Retiree with Spouse both covered by Medicare..... \$40.00

\_\_\_\_\_

These rates may change in the future.

LATE SELF-PAYMENT FEES WILL NOT BE ACCEPTED. Payment is due on the first day of each month for that month. Once any payment is late, there is no further right to self-pay. You are welcome, but not required to put a security deposit down. This will allow an extra 30-day grace period in the instance you do not make a payment. If you do not have the security deposit and fail to make a payment, your coverage will terminate and you cannot be reinstated. If there is a deposit, we will use it to make that month's payment so there is no lapse in your coverage.

**ELECTION OF SELECTION OF MEDICARE RETIREE MEDICAL COVERAGE**

I (WE) UNDERSTAND THE NON-MEDICARE RETIREE MEDICAL COVERAGE PROVISIONS AND ELECT NON-MEDICARE RETIREE MEDICAL COVERAGE AS CHECKED ON THE PREVIOUS PAGE OF THIS FORM.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Spouse or  
Child(ren)'s Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

*Return this Form within 60 days to:*

**St. Louis Graphic Arts Joint Health & Welfare Fund  
14323 South Outer Forty Rd.  
Suite S106  
Chesterfield, Missouri 63017**