IBEW LOCAL 234 HEALTH AND WELFARE PLAN

RETIREE HEALTH AND WELFARE APPLICATION

Member's Name: ____

SSN or Member ID: ____

Address: ____

Birth Date: ______/_______/_______ Single _______ Married _______ Divorced _______

Effective Date of Retirement: ______/______/______

1. I am applying for the following Retiree Health and Welfare Coverage:

   a. ______ Normal (Age 62)

   b. ______ Early (Age 55-62)

   c. ______ Temporary Disability (please attach current physician's statement, continued proof may needed)

   d. ______ Permanent Disability

   e. ______ Dependent Only (surviving spouse/surviving dependent)
   If applying for Dependent Only benefits please attach a copy of the member's death certificate

2. Have you applied for Social Security Disability Benefits? YES ________ NO ________

   If you answered yes, please attach a copy of your Social Security Award.

3. Please list all dependents that will be continuing on the Retiree Health Care Plan (including spouse):

   a. ______________________________________ c. ______________________________________

   b. ______________________________________ d. ______________________________________

4. Are you or any of your dependents on Medicare? YES ________ No ________

   If you answered yes, please attach a copy of each Medicare card (must have Parts A and B).

I hereby apply to the I.B.E.W. Local 234 Health and Welfare Trust for participation in the Retiree Program. I agree to notify the Administrator of the Fund in writing whenever I return to work in the industry. I also agree that my participation is to be governed in all respects by the provision of the Fund, or as the same may hereafter be amended, and the making of any monthly payment by me in the amount and manner as established by the Fund.

____ __________________

Signature of person applying for benefits Date