THE UMWA Health and Retirement FUNDS

APPLICATION FOR HEALTH BENEFITS

ALL APPLICATIONS FOR HEALTH BENEFITS SHOULD BE SENT TO:

UMWA Health & 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

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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:

- You are a retired or disabled mine worker who is receiving a 1950 Pension Plan pension, unless you are receiving a Partial Pension and used non-classified (supervisory) service to meet the minimum vesting requirements.
- You are in a certain class of disabled mine workers who are not eligible for a pension from the Funds.
- You are in a certain class of retired or disabled mine workers who are receiving a 1974 Pension Plan pension (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 worker 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—UMWA COMBINED BENEFIT FUND, UMWA 1992 BENEFIT PLAN, OR UMWA PREFUNDED BENEFIT PLAN (CARBONTRONIX)—If you are eligible for benefits from the UMWA Combined Benefit Fund, the UMWA 1992 Benefit Plan or the UMWA Prefunded Benefit Plan (Carbontronix), 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.
- Children age 22 or older who are intellectually disabled or who were disabled before the age of 22 if the child's disability is continuous and the child lives in the same household as the retired or disabled mine worker or is confined to an institution for care and treatment. Documentation from a medical doctor or psychologist must be provided to substantiate the dependent's inability to live and function independently.
- Unmarried grandchildren under the age of 22 who are living in the same household as you and are being supported by you.
- A parent or parent-in-law if the parent has been dependent upon and living in the same household with you for a continuous 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.

ELIGIBILITY OF DEPENDENTS OF RETIRED OR DISABLED MINE WORKERS—UMWA 1993 BENEFIT PLAN OR UMWA PREFUNDED BENEFIT PLAN (ENERGY WEST)—If you are eligible for benefits from the UMWA 1993 Benefit Plan or the UMWA Prefunded Benefit Plan (Energy West), 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 26.
- Children age 26 or older who are intellectually disabled or who were disabled before the age of 26 if the child's disability is continuous and the child lives in the same household as the retired or disabled mine worker or is confined to an institution for care and treatment. Documentation from a medical doctor or psychologist must be provided to substantiate the dependent's inability to live and function independently.
- Unmarried grandchildren under the age of 22 who are living in the same household as you and are being supported by you.
- A parent or parent-in-law if the parent has been dependent upon and living in the same household with you for a continuous period of at least one year.

Note: A grandchild or parent shall be considered dependent upon the retired or disabled miner, or spouse, if such retired or disabled miner or spouse provides over one half of the support to such person.

SURVIVING SPOUSE OF A DECEASED MINE WORKER—In general, a surviving spouse who has not remarried is eligible for Funds health benefits if the deceased mine worker was eligible for Funds pension and health benefits at the time of death, or if the mineworker died as a result of 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:

- You are the surviving spouse of a deceased mine worker who was receiving a 1950 Pension Plan pension at the time of death.
- You are a surviving spouse who is receiving a 1974 Pension Plan surviving spouse pension.
- You are the surviving spouse of a mine worker who died as a result of a mine accident while he or she was employed in a classified job for a signatory employer.

ELIGIBILITY OF DEPENDENTS OF SURVIVING SPOUSES—UMWA COMBINED BENEFIT FUND, UMWA 1992 BENEFIT PLAN, OR UMWA PREFUNDED BENEFIT PLAN (CARBONTRONIX)

If you are a surviving spouse who is 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.
- Surviving children age 22 or older who are intellectually disabled or who were disabled before the age of 22 if the child's disability is continuous and the child lives in the same household as the surviving spouse or is confined to an institution for care and treatment. Documentation from a medical doctor or psychologist must be provided to substantiate the dependent's inability to live and function independently.

If there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, the surviving children may be eligible for Funds health benefits for a limited period but in no event beyond their attaining age 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).

ELIGIBILITY OF DEPENDENTS OF SURVIVING SPOUSES—UMWA 1993 BENEFIT PLAN OR UMWA PREFUNDED BENEFIT PLAN (ENERGY WEST)

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

- Surviving children under the age of 26.
- Surviving children age 26 or older who are intellectually disabled or who were disabled before the age of 26 if the child's disability is continuous and the child lives in the same household as the surviving spouse or is confined to an institution for care and treatment. Documentation from a medical doctor or psychologist must be provided to substantiate the dependent's inability to live and function independently.

If there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, the surviving children may be eligible for Funds health benefits for a limited period but in no event beyond their attaining age 26.

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:

- ☐ **Complete all pages of this application.**
- ☐ **Sign the application on page 6 when complete.**
- ☐ **Each person, including dependents, must sign the Medicare Authorization form on page 8, even if he or she is not currently eligible for Medicare. Parents or legal guardians should sign for minor dependents.**
- ☐ **Attach a copy of your marriage certificate, if applicable.**
- ☐ **Attach a copy of the birth certificate for each person included on the application.**
- ☐ **For adopted children or custodial dependents, please attach a copy of the Adoption Decree, Custody Order, or related documents.**

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Health Services Card Application

Information about the Mine Worker

NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
MAILING 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

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

Information about the Applicant if other than Mine Worker

NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
MAILING 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 (FIRST, MIDDLE, LAST)	AREA CODE & TELEPHONE NUMBER

MAILING 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)	SOCIAL SECURITY NUMBER	ENROLLED IN MEDICARE YES/NO

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	DID THE MINE WORKER DIE AS A RESULT OF A MINE ACCIDENT? ❑ YES	❑ NO
HAVE YOU REMARRIED SINCE THE MINE WORKER'S DEATH?	❑ YES	❑ NO

Complete this section only if the mine worker died as a reult of a mine accident.

NAME OF COAL COMPANY	DATE OF MINE ACCIDENT
MINE NAME OR NUMBER	MINE WORKER'S JOB CLASSIFICATION

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.

MINE WORKER'S OR SURVIVING SPOUSE'S SIGNATURE **DATE**

PRINT NAME **SOCIAL SECURITY NUMBER**

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 of Mine Worker or Surviving Spouse

(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 POLICY HOLDER

NAME OF ORGANIZATION PROVIDING THE COVERAGE

GROUP POLICY NUMBER

ADDRESS OF INSURANCE COMPANY

_____

_____

_____

CITY STATE ZIP

_____

PHONE NUMBER

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Authorization to Obtain Medicare Information

Each person, including dependents, must sign this Medicare Authorization form, even if he or she is not currently eligible for Medicare. Parents or legal guardians should sign for minor dependents.

Mineworker Name (First, Middle, Last)		Social Security Number:
Medicare Claim Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date

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

Dependent Name (First, Middle, Last)		Social Security Number:
Medicare Claim Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date

Dependent Name (First, Middle, Last)		Social Security Number:
Medicare Claim Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date

Dependent Name (First, Middle, Last)		Social Security Number:
Medicare Claim Number	Hospital (Part A) Effective Date	Medical (Part B) 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: _____