UNITED WORKERS HEALTH FUND
367 LONG BEACH ROAD 147
ISLAND PARK, NY 11558
888-666-1974
Fax 516-706-0879

NORTH EAST

United Workers Health Fund Benefit Tier Selection

- o I Choose Parent + one (1) child option. I understand that my obligation under this option is that the company will deduct a total of $200.00 per month from my Pre Tax Pay.

- o I Choose Spouse/Family option. I understand that my obligation under this option is that the company will deduct a total of $400.00 per month from my Pre Tax Pay.

- o I Choose to terminated my above designation effective _____
  I understand that by terminating my family members coverage, that I will remain in single coverage as per the Collective bargaining agreement at no cost to me. My family members will not be eligible to return to coverage until the next open enrollment or life event.

Print Employees Name:_____

Signature:_____Date:_____

UNITED WORKERS HEALTH FUND
367 LONG BEACH ROAD 147
ISLAND PARK, NY 11558
888-666-1974
Fax 516-706-0879

CHICAGO

United Workers Health Fund Benefit Tier Selection

- I Choose Single option. I understand that my obligation under this option is that the company will deduct a total of $68.00 bi-weekly from my Pre Tax Pay. My cost will decrease to $67.00 bi-weekly effective 1-1-2016 to 9-30-2018.

- I Choose Parent + one (1) child option. I understand that my obligation under this option is that the company will deduct a total of $135.00 bi-weekly per month from my Pre Tax Pay. My cost will decrease to $125.00 bi-weekly effective 1-1-2017 to 9-30-2018.

- I Choose Spouse option. I understand that my obligation under this option is that the company will deduct a total of $140.00 bi-weekly from my Pre Tax Pay. My costs will increase to $184.00 bi-weekly effective 1-1-2016 to 9-30-2018.

- I Choose Family option. I understand that my obligation under this option is that the company will deduct a total of $200.00 bi-weekly from my Pre Tax Pay. My costs will decrease to $195.00 bi-weekly effective 1-1-2016 to 12-31-2016. Effective 1-1-2017 my costs will decrease to $190.00 until 9-30-2018.

- I Choose to Waiver/terminated my coverage or any previous designation that I may have made effective _____.
  I understand that by terminating any tier of coverage, that I and my family members will not be eligible to return to coverage until the next open enrollment or life event.

Print Employees Name:_____

Signature:_____Date:_____