Southern California Local 831 Employer Health Fund

RETIREE HEALTH COVERAGE ELECTION/PREMIUM DEDUCTION AUTHORIZATION

If you are a retiree interested in retiree health coverage or a retiree already receiving retiree health coverage under the Local 831 Employer Health Fund (the "Health Plan"), please complete the following and return to the Health Plan Office as soon as possible. Please note that if you elect this coverage you are required to make monthly premium payments to the Health Plan through an "after tax" and "voluntary" premium deduction from your monthly pension check from the Local 831 Employer Pension Fund.

Election for Retirees, Spouses, and/or Dependent Children NOT Eligible for Medicare

☐	I elect retiree health coverage and agree to have the premiums withdrawn from my monthly pension check.

Retiree's Last Name:	First Name:	MI:	Soc. Sec. No.:	
Street Address:	City:		State:	Zip:
Home Phone:	Daytime Phone:		DOB:	

IMPORTANT NOTICE: RETIREE HEALTH COVERAGE IS NOT AVAILABLE TO YOU OR TO YOUR DEPENDENTS IF YOU ARE, OR WHEN YOU LATER BECOME, ELIGIBLE FOR MEDICARE. HOWEVER, IF YOU BECOME ELIGIBLE FOR MEDICARE BECAUSE OF A DISABILITY BEFORE YOU TURN AGE 65, YOUR DEPENDENTS WILL BE ABLE TO CONTINUE RETIREE HEALTH COVERAGE FOR THE SAME DURATION AS IF THEY HAD INSTEAD ELECTED COBRA CONTINUATION COVERAGE.

EVEN IF YOU ARE ENTITLED TO RETIREE HEALTH COVERAGE, IT IS NOT AVAILABLE TO A DEPENDENT IF THE DEPENDENT IS, OR WHEN THE DEPENDENT LATER BECOMES, ELIGIBLE FOR MEDICARE.

Rates are as of January 1, 2026

I ELECT retiree health coverage at the following level and Plan option (circle one of each):			
☐ Level 1: $ 1,876.00 *(Full Coverage)*	☐ Level 2: $ 1,608.00 *(Full Coverage)*	☐ Level 3: $ 1,340.00 *(Medical, Dental & Rx)*	☐ Level 4: $ 1,072.00 *(Medical Only)*
☐ Indemnity Plan		☐ Kaiser Plan	
You will automatically be enrolled in the level of coverage and Plan option that you had on your last day as an Active Participant. However, you may choose to elect a lower level of coverage now or at any time in the future. You are only allowed to increase your level of coverage or switch between the Kaiser and Indemnity Health Plan options one time during the twelve (12) month period after you have elected retiree health coverage. A new assignment will be required every year.			
☐ I DO NOT wish to elect retiree health coverage.		☐ I wish to CANCEL my retiree health coverage and all premium deductions.	

WARNING: I understand that by **not electing** retiree health coverage or by **canceling** my retiree health coverage at this time, I can NEVER elect retiree health coverage under the Health Plan again.

* *If you meet the eligibility requirements and enroll in retiree health coverage provided through the Health Plan, you may also enroll your children and your lawful spouse as dependents, provided that (1) your children and spouse become enrolled in retiree health coverage at the same time that you enroll; (2) your children and spouse were covered under the Active Health Plan when you first became eligible for retiree health coverage; and (3) your spouse agrees, in writing, to receive retiree health coverage from the Health Plan instead of electing COBRA continuation coverage, which would result in a waiver of their right to participate in COBRA continuation coverage. You may not later add your children or your lawful spouse even if you were not married at the time you enrolled in the Health Plan and subsequently married, or if you divorced and subsequently re-married.*

Note: If you are, or become, covered under your spouse's plan, or become covered under our Active Health Plan, you may suspend coverage and premium payments under this Retiree plan while you are so covered. But you must provide the written notices explained on page [74] of the SPD.

Provide the name, address and details of any other group health plan that you, your spouse, or your dependent children are covered under through your or their employment:

Provide the name(s) of your spouse/dependents, if any, that you would also like covered:

I hereby authorize the Pension Fund Office on behalf of the Pension Plan to deduct from my monthly pension benefit payment, on an after-tax basis, the amount (but not to exceed my gross monthly pension benefit after withholdings for income taxes) that has been determined by the Trustees of the Health Plan to be paid by me as a retiree participant in the Health Plan, to maintain my retiree health coverage in full force and effect.

I understand that I **am under no obligation** to enter into this arrangement for the payment of the retiree share of retiree health coverage, and that this assignment of benefits to the Health Plan for this purpose may **be revoked** at any time.

I also understand that this is on an "after- tax" basis and that this election will not affect the gross income that will be reported to the Internal Revenue Service on my behalf.

For those with post-retirement work hours, employer contributions made towards retiree health coverage will be reviewed quarterly.

Signature of Participant:	Date:
Signature of Spouse:	Date: