Plumbers and Steamfitters Local Union No. 248
Health and Welfare Trust Fund
333 West Vine Street • Suite 500 • Lexington, Kentucky 40507
Toll-Free 888-999-7741 • Fax 859-226-1191

APPLICATION FOR THE MEDICARE GAP FILLER BENEFITS

INSTRUCTIONS:

1. Complete this application by filling in the blanks and selecting the class of benefits which applies to you.
2. Attach your check in the amount indicated for the class of benefits which applies to you.
3. Attach a copy of your Medicare Benefits card to verify eligibility for Medicare Hospital and Medical insurance.
4. Sign, date and mail this application and attachments to the attention of Marissa Wallace at the above address.

Member's Name _____

Street Address _____

City, State, Zip _____

Social Security Number _____

Date of Birth _____

Spouse's Name _____

Spouse's Social Security Number _____

Spouse's Date of Birth _____

SELECT THE CLASS OF BENEFITS THAT APPLIES TO YOU:

Please Check	Benefit Class	Monthly Cost
☐	Single Applicant receiving Medicare *(If you and your spouse are covered participants at the time of your retirement and you elect this option, your spouse must sign acknowledging that he/she will no longer be covered under the plan. That by signing this waiver I acknowledge that I forfeit my right to participate in the Plumbers and Steamfitters Health & Welfare Plan and will not be allowed to reenter the plan at a later date.)*	$175.00
	Spouse's Signature _____ Date	
☐	Applicant and Spouse receiving Medicare	$350.00
☐	Applicant receiving Medicare and Spouse receiving Anthem BCBS	$620.00
☐	Applicant receiving Medicare and Spouse plus Dependent Children receiving Anthem BCBS	$890.00

SIGNATURE OF MEMBER: _____ _____
DATE SIGNED

PLEASE PRINT NAME: _____