# BAY AREA ROOFERS HEALTH & WELFARE TRUST FUND

**P.O. BOX 5057, SAN JOSE, CA 95150-5057**

## RETIREE ENROLLMENT APPLICATION

RETIREE NAME: _____ SSN# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ LOCAL NO. _____

NAME OF SPOUSE: _____ SPOUSE SSN# _____

RETIREE DATE OF BIRTH: _____ SPOUSE DATE OF BIRTH: _____

NAME(S) OF DEPENDENT CHILDREN (IF APPLICABLE) - NOTE: Dependent Children are defined as unmarried children to the age of 19 fully dependent on you for support. Children between age 19 to 24 years of age may also be included if they are students at an accredited school and fully dependent on you for support.

| Name | Date of Birth | Social Security No. |
|---|---|---|
| | | |
| | | |
| | | |

Effective date of your Retiree Coverage _____

Eligible persons to be covered (check one):

Self only: ☐ Self & Spouse: ☐ Self & Spouse & Children: ☐

Are you on Medicare Part B? Yes ☐ No ☐ (Retirees over 65 must have Medicare Part B)

Type of coverage applied for (check one):

Medical & Rx Only: ☐ Medical with the additional package (Life, Dental & Vision): ☐

Name of Retiree Life Insurance Beneficiary _____

Relationship _____

I hereby apply for the coverage indicated above and acknowledge that the eligibility rules of this Trust will not allow me to add any coverages in the future. If electing the additional package, I understand that I will not be eligible to discontinue these additional coverages until a minimum of 12 consecutive months coverage has elapsed. I furthermore agree to abide by the eligibility rules of the plan and agree to make the required monthly contribution.

_____

Retiree Signature Date