Instructions for Non-Active Classification Self-Pay Application

1. Prior to completing the ***Non-Active Self-Pay Application*** process, please call our Member Service Department to verify this is the best coverage option available to you.

2. When completing the ***Non-Active Self-Pay Application***, make sure Sections 1 – 6 are completed in full.

3. If you determine you qualify for non-active self-pay classification coverage, you must include a check for your first premium due with this application in the amount as calculated in **Section 4: Determine Your Monthly Premium Amount**. Payment must be received within 15 days of the date listed in **Section 2: First Premium Payment Due**.

4. A ***Payment Authorization Form*** is available if you want to elect an automatic payment method *(highly recommended)* for ongoing payments. You will need to send payments by check until you receive confirmation of the date the automatic payments will go into effect.

5. Once you have completed the ***Non-Active Self-Pay Application***, mail the form and payment to:

   Carpenters Benefit Plans
   1419 Hampton Ave
   St. Louis, MO 63139

6. You will receive a letter confirming your non-active classification status once this application has been processed.

Should you have any questions, please contact our office Monday – Friday, 8 am – 4:30 pm:

By phone: (314) 644-4802
Toll-Free: (877) 232-3863
Email: benefits@carpdc.org

Enclosures: Non-Active Self-Pay Application
Payment Authorization Form

Non-Active Classification Self-Pay Application

1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802 Toll-Free: (877) 232-3863 Email: benefits@carpdc.org

CARPENTERS BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Member Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Last 4-digits of SSN

1. **First Self-Payment Due Date** *(MM/01/YYYY)*	2. **First Non-Active Classification Coverage Month** *(MM/YYYY)* *(Month after first self-pay due date)*

3. **Qualification Verification** - *Contact our office if you need assistance with answering these questions*

A. Do you currently have coverage through the Carpenters' Health Plan under the Active Classification? ☐ YES ☐ NO

B. Are you drawing a pension or totally disabled from working in the trade? ☐ YES ☐ NO

Pension effective date (if applicable): _____ *Disability date (if applicable):* _____

Pension fund: ☐ *St. Louis* ☐ *Kansas City* ☐ *Kansas Building Trades* ☐ *Geneva*

C. Are your union dues current with your Local? ☐ YES ☐ NO

Local # _____ For questions about your union local status, call (314) 644-4800 or (800) 332-7188

D. Do you have at least 3 years of Active Classification* coverage within the last 5 years under the Carpenters' Health Plan? ☐ YES ☐ NO

E. Do you have at least 10 years of Active Classification* coverage under the Carpenters' Health Plan during your career? ☐ YES ☐ NO

*Active Classification includes hours bases eligibility, Minimum/Difference Payments and COBRA.

Did you answer **YES** to **all** of the questions above? If so, you qualify for this Non-Active Classification coverage. Proceed to #4.

Did you answer **NO** to **any** question above? If so, you do not qualify for this Non-Active Classification coverage. If you are/were working for a union employer in a non-bargaining position and you are losing coverage with that employer, you may still qualify. Contact our office for further instructions.

4. **Determine Your Monthly Premium Amount** - *The questions below will assist you in calculating your monthly rate:*

Medicare Participants
Coverage for Medicare eligible dependents is provided through UnitedHealthCare's Medicare Advantage Plan. Please attach a copy of your Medicare card, Parts A & B.

Are you (member) eligible for Medicare? Enter **$275** for Yes Enter **$605** for No	$
Do you want Single or Family Coverage? Enter $0 for Single For Family, enter **$275** if you have one dependent eligible for Medicare or enter **$605** for no dependent Medicare	$
Do you want Dental Coverage? If No, enter **$0**. If Yes, enter **$35** for Single or enter **$70** for Family. $ *If you select Family medical coverage and you want dental, you must select Family dental coverage.*	$
Add the three lines above for your **Monthly Premium Amount**	$

5. **Family Only Coverage** - *Complete this section if you selected Family Coverage:*

Spouse Name	Date of Birth (MM/DD/YYYY)	Eligible for Medicare? ☐ Yes ☐ No If yes, attach copy of your Medicare card	Other Group Coverage? ☐ Yes ☐ No

Dependent Name	Date of Birth (MM/DD/YYYY)	Eligible for Medicare? ☐ Yes ☐ No If yes, attach copy of your Medicare card	Other Group Coverage? ☐ Yes ☐ No

6. **Signature**

I have answered all of the above questions to the best of my knowledge and with my signature, I am authorizing the Carpenters' Plan to contact the Regional Council and my pension fund to verify the information provided. I also understand there are no Short Term Disability benefits while covered in this Non Active Classification.

Member Signature (REQUIRED) _____ Date _____ Best Contact Phone Number _____

OFFICE USE: Employee Name _____ Date _____ Medicare Packet Included: ☐ Yes ☐ No

Self-Payment Authorization Form

St. Louis - Kansas City Carpenters Regional Health Plan (Plan)
Benefit Plans Office - 1419 Hampton Avenue - St. Louis, MO 63139
Phone: (314) 644-4802| Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@carpdc.org

Member Name:

Last 4 Digits of Member SSN:

Please complete the form and return it to the Carpenters' Benefit Plans Office. **Note:** ***You will need to continue paying your monthly premiums until you receive verification from our office confirming your automatic payment effective date.***

To the Trustees of the St. Louis - Kansas City Carpenters Regional Health Plan (Plan), I hereby request that my health and welfare contributions, payable by me, be processed through the following Payment Option:

Please select ONLY ONE Payment Option

Option 1 - ☐ Deduct from my Pension Benefit (Preferred Method)

What Plan is your pension benefit from: ◯ St. Louis ◯ Kansas City

Net Monthly Pension Amount* (after income tax and union dues deductions, if applicable): $ _____

*Net Monthly Pension Amount must be equal to or greater than requested premium amount.

(Note: If you have a Geneva or a KBT Pension or are a COBRA participant, this option is not available to you.)

Option 2 - ☐ Debit from bank account: ◯ Checking Account ◯ Savings Account

Attach a voided check

Use account information from your statement not your deposit slip

Name of Financial Institution:

Transit Routing Number:

City and State of Financial Institution:

Bank Account Number:

Option 3 - ☐ Auto Pay from Credit Card: ◉ **Master Card** ◯ **Visa** ◯ **Discover**

Credit Card Account Number:

Expiration Date:

Printed Name of Card Holder:

Signature of Card Holder:

I understand the Trustees have discretion whether to comply with this request. I understand I may cancel or change this authorization for payment from the account selected above by written notice to the Plan at least ten days prior to the first day of the month for that month's payment processing. I certify this authorization will remain in effect until either (1) I provide written notice to cancel this request, or, in the case I have elected Pension Deduction above, (2) my health and welfare benefit is greater than my pension benefit and therefore pension deduction is no longer possible. My signature on this authorization indicates that I authorize the verification of the above information by the financial institution of the Plans' Trustees or their designated representative. I consent that a copy of this authorization may be considered as valid as the original.

I also understand the date the deduction will begin and the current rate will be verified with the Benefit Plans Office. Also, Option #1 is not possible if Health and Welfare contribution exceeds monthly Pension Benefit.

Member Signature: Date:

If you have any questions, please contact the Carpenters' Member Services Department:

For Office Use Only

Rate Type: Amount: Pymt Effective Date: Auth By & Date: