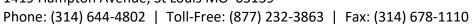# Military Leave of Absence- Active Duty/Release/Discharge Form

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
1419 Hampton Avenue, St Louis MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110

Member Name (Last, First, Middle Initial)	Member Social Security Number

Form Instruction:
➤ **Complete Section A to report your Order for Active Duty and request to freeze your coverage. Then proceed to Section C.**
➤ **Complete Section B to report your release/discharge from Active Duty and request to re-instate your coverage. Then proceed to Section C.**

A. Report to Active Duty

Active duty service members of the uniformed services are eligible for TRICARE and therefore, you may not need your Carpenters' coverage during your time of service. If you have accrued coverage that extends beyond the date you have been ordered to report to Active Duty, you have the option of freezing this coverage until you return from Active Duty. If you elect to do this, your coverage will be re-instated upon receipt of your discharge/release papers.

Date ordered to report to Active Duty:_____ Please attach a copy of your Report to Active Duty Orders.

☐ 1. Please freeze my health and welfare coverage for me (and my dependents, if applicable) effective the first day of the month following the Active Duty date above. (Example: If I have six months of available coverage, upon my discharge from Active Duty, the Plan will reinstate my health and welfare coverage for six months.)

   a. *If you have a spouse and/or dependents:*
   Your coverage and your dependents/spouse coverage will freeze as stated in #1 above. While your coverage is in this status, your dependents/spouse (if applicable) have the option of continuing under COBRA coverage for up to a maximum of 18 months by paying a COBRA premium. If you want the plan to provide a COBRA Election Notice to your dependents, please check here. ☐

B. Release/Discharge from Active Duty

Upon release/discharge from Active Duty, your Carpenters' coverage will be reinstated the first day of the month following your discharge date

Date discharged/released from Active Duty:_____ Please attach a copy of your Release/Discharge papers.

Please check one:

☐ 1. Please reinstate my health and welfare coverage the first of the month following the above Release/Discharge from Active Duty date.

☐ 2. Please reinstate my health and welfare coverage on the first of the month indicated here (MO/YR): _____
The latest reinstatement date you can request is the first day of the month following your TRICARE coverage termination date.
   a. Please furnish your TRICARE coverage termination date:_____ If you have a Certificate of Creditable Coverage from TRICARE, please include it when you return this form.

C. Signature

_____   _____
Member Signature (REQUIRED)   **Date**