LOCAL 103, I.B.E.W.
HEALTH BENEFIT PLAN
256 FREEPORT STREET, BOSTON, MASSACHUSETTS 02122
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LOCAL 103

NECA GREATER BOSTON

TOLL FREE: (800) 564-5999
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RICHARD P. GAMBINO, ADMINISTRATOR
MICHAEL P. DONOVAN, CFO

Medicare Part D

Please read and complete all applicable portions of this form and return the completed form to the address shown above by November 7, 2017. If you should have any questions, please contact the Fund Office.

Participant's Full Name: _____

Participant's Social Security Number: _____Date of Birth: _____/_____/_____

Complete the following if you are married, divorced or widowed:

Spouse's Full Name: _____

Spouse's Social Security Number: _____Date of Birth: _____/_____/_____

If Spouse is Deceased, Date of Death: _____

If Divorced, Date of Divorce: _____

1. **Will you be enrolled in a Medicare Part D prescription drug plan on or after December 1, 2017?**
   ☐ **YES** ☐ **NO**
2. **Will your spouse be enrolled in a Medicare Part D prescription drug plan on or after December 1, 2017?**
   ☐ **YES** ☐ **NO**

Participant's Certification

I hereby certify under the pains and penalties of perjury that the information and statements provided by me on this form are true and complete. I understand that I am obligated and required, as a condition of accepting coverage under the Plan, to notify the Plan in the event of the following:

- If I have listed a spouse, I certify that I am legally married and that my spouse is living at the time of my signature on this form. I agree and understand that I am required to notify the Plan immediately if I am no longer legally married to the spouse that I have listed (for example, if we are divorced), or if my spouse dies.
- If I have answered that I am not enrolled in a Medicare Part D prescription drug plan, and will not be so enrolled on December 1, 2017, I understand that I am obligated and required to immediately notify the Plan if I later become enrolled in a Medicare Part D prescription drug plan.
- I understand that if I enroll in a Medicare Part D prescription drug plan on or after December 1, 2017 that I will be required to pay a premium in an amount determined annually by the Trustees of the Plan in order to maintain my Supplemental Plan coverage and that my Supplemental Plan coverage will terminate if I fail to timely make payment of the premium.

I understand that the Fund will rely upon my certification and representations made in this enrollment form.

_____ _____

Signature of Participant Date