Local 103, I.B.E.W.
Health Benefit Plan

256 Freeport St., 2nd Floor, Boston, MA 02122
Telephone (617) 288-5999
www.trustfunds103.com

Toll Free: (800) 564-5999
Fax: (617) 288-6696

Michael P. Donovan, Administrator

IMPORTANT NOTICE

TO: Local 103, I.B.E.W. Supplemental Plan Participants
DATE: December 4, 2018
SUBJECT: Medicare Part D

Medicare Part D (Blue Form)

Our records indicate you or one of your dependents are eligible or will become eligible for Medicare Part D during the upcoming Plan Year. The Local 103, I.B.E.W Health Benefit Plan sends out this Medicare Part D form annually. ***All Supplemental Plan participants must complete the enclosed Medicare Part D (Blue Form) and return it before December 31, 2018.*** This Form must be returned to continue coverage under the Supplemental Plan. ***Failure to return the completed form will result in suspension and / or termination of your coverage.***

Part D Notification

Accompanying the Medicare Part D (Blue Form) is the Part D Notification. The purpose of this notice is to explain to you the additional annual premium that will be charged to each Supplemental Plan participant who is also enrolled in a Medicare Part D plan.

If you need to obtain another copy of the Medicare Part D form, please visit our website at www.trustfunds103.com or call the Trust Funds Office at (617) 288-5999. ***Please remember to complete the enclosed form and to return both by December 31, 2018 to avoid loss of coverage.*** For your convenience, a return envelope has been included in this packet.

Please Mail Form to: Local 103, I.B.E.W, Health Benefit Plan
Health Re-Enrollment
256 Freeport Street, 2nd Floor
Boston, MA 02122

Medicare Part D

Please read and complete all applicable portions of this form and return the completed form to the address shown above by **December 31, 2018**. If you should have any questions, please contact the Trust Funds Office.

Participant's Full Name: _____
Participant's Social Security Number: _____Date of Birth: _____/_____/_____
Phone number: _____

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, 2018?

☐ **YES** ☐ **NO**

2. Will your spouse be enrolled in a Medicare Part D prescription drug plan on or after December 1, 2018?

☐ **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, 2018, 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, 2018, 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