

## 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 15, 2021. If you should have any questions, please contact the Fund 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, 2021?

YES  NO

2. Will your spouse be enrolled in a Medicare Part D prescription drug plan on or after December 1, 2021?

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, 2021, 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, 2021, 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