IBEW-NECA
SOUTHWESTERN HEALTH AND BENEFIT FUND

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MEDICARE ADVANTAGE PLAN ELECTION

This election form confirms that you are opting in to the UHC Medicare Advantage Plan and understand that you cannot make any plan changes until the annual open enrollment period next year.

Complete and Return the form below

Member Information:

Name: ____
Physical Address:____
Mailing Address:____
Home Phone:___________________ **Cell Phone:**__________________________
ID #:________________________ **Date of Birth:**________________________
Spouse's Name:____
Spouse's ID #:________________ **Date of Birth:**________________________
Medicare ID #:______________________
Spouse's Medicare ID #:_______________ **Effective Date:**
Medicare Part A:_____________
Medicare Part B:_____________

Name of Dependent Children

Name: _______________________ **ID #:** _________________ **Date of Birth:** ________________
_______________________ _________________ ________________ _______________________
_________________ ________________

PLEASE INCLUDE A COPY OF MEDICARE CARD (RED/WHITE/BLUE MEDICARE CARD)

I hereby agree to abide by the rules set forth by trustees of the fund to make payments no later than the 15th of the month for which it is intended, and certify the above information is true and correct.

____________________________ ___________________
Signature of Retiree/Applicant **Date**