Middletown Works Hourly & Salaried
Union Retirees Health Care Fund
1201 Crawford Street • Middletown, OH 45044
PH: (513) 217-4818 • TOLL FREE: (877) 392-9991 • Fax: (513) 672-9622

Retiree Opt-In

Participant Information

(Please type or print clearly)

Name:_____

Social Security Number: _____ Telephone Number: _____

Address: _____

_____

☐ I want to add medical and prescription drug coverage for myself.

☐ I want to add coverage for my dependents. *Please complete the following information.*

			Check here if dependent has other coverage or Medicare
Spouse's Name	Date of Marriage	Birth Date	☐
Dependent's Name	Natural Child-yes or no (if no, please indicate the date this person became your dependant)	Birth Date	☐
Dependent's Name	Natural Child-yes or no (if no, please indicate the date this person became your dependant)	Birth Date	☐

This election is effective as of (insert date): _____

Authorization

I choose to elect coverage under the Middletown Works Hourly and Salaried Union Retirees Health Care Fund as of the effective date listed above. Please contact the Fund Office to get information about how to pay your premium, including information on authorizing payment through a deduction from your checking or savings.

Participant's Signature: _____ Date: _____

To resume coverage for yourself and/or your dependent, you must:

- *Submit this form and*
- *Pay the required monthly premium for coverage, at the rate in effect when coverage resumes.*