SOUTHERN CALIFORNIA PIPE TRADES
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 385-2767 | www.scptac.org

SURVIVING SPOUSE MEDICAL & DENTAL ENROLLMENT FORM

DEADLINE: 180 DAYS FROM date coverage terminated under participant's plan

Surviving Spouses of deceased Participants in the Southern California Pipe Trades Health & Welfare Fund, or in the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund receive a minimum of three months of medical coverage. Surviving Spouses may choose to continue medical coverage under the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund by using this form to enroll in the Surviving Spouse Self-Pay Program and paying the required monthly medical premium.

Dental: Surviving Spouses who are **eligible for and elect** benefits under the terms of the Pensioner & Surviving Spouses Health Plan may also choose to purchase coverage in **one** of the two Cigna Dental HMO options as listed in Section 2 of this form, at the time he or she first becomes eligible for Plan benefits, and thereafter during an annual open enrollment period.

You may terminate your coverage for medical and/or dental at any time by submitting a written request to the Fund office.

Payment: The current medical premium for the Surviving Spouse Self-Pay Program is $140 per month (not including Dental); dental premiums are listed below and depend on your election. If you elect dental, you must make a payment through pension benefit deduction or, if none is available, through ACH deduction. If you are electing medical coverage only, you may use any of the options mentioned or send a check.

SECTION 1—DECEASED PARTICIPANT INFORMATION

Deceased Participant Name ____________________

Social Security Number (only last 4 required) ____________________

SECTION 2—SURVIVING SPOUSE INFORMATION

Surviving Spouse Name ____________________

Social Security Number (only last 4 required) ____________________

Address ____________________

City, State, ZIP Code ____________________

Date of Birth (required) ____________________

Phone Number ____________________

Email Address ____________________

(You must use a U.S. address in order to qualify for Cigna Dental benefits.)

SECTION 3—DENTAL BENEFIT ELECTION (check one)

I elect the following dental benefit option:	Monthly Cost
A ☐ **NO DENTAL COVERAGE**	**Skip to Section 5**
B ☐ **CIGNA DENTAL HMO PLAN P1-00**	$32.48
C ☐ **CIGNA DENTAL HMO PLAN L1-09**	$13.72

SIX-DIGIT CIGNA DHMO OFFICE NUMBER (OPTIONAL): ____________

SECTION 4—Medicare (check one)

Are you eligible for Medicare?

☐ **Yes**

☐ **No**

 (Continued on reverse…)

SECTION 5—ACH ELECTRONIC PAYMENT AUTHORIZATION

YOU SHOULD COMPLETE THIS SECTION IF YOU ARE ELECTING TO PAY FOR YOUR MEDICAL OR YOUR MEDICAL AND DENTAL COVERAGE THROUGH AN AUTOMATIC, MONTHLY DEDUCTION THROUGH YOUR BANK ACCOUNT. HOWEVER, IF YOU ARE ELECTING BOTH **MEDICAL AND DENTAL** COVERAGE AND ARE **NOT** RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND, YOU ARE **REQUIRED** TO PAY THROUGH AN ACH ELECTRONIC PAYMENT AND YOU **MUST** COMPLETE THIS SECTION.

By signing in Section 6 below, I authorize the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund to electronically withdraw from or deposit into my checking or savings account indicated below amounts necessary to provide dental benefits as determined by the Board of Trustees of the Fund.

Depository Name (Bank, Savings & Loan or Credit Union)	
Transit/ABA/Routing Number	**Account Number**
Account Type ☐ **Checking** ☐ **Savings**	**Email Address** (**Fund's bank may notify you of withdrawals or deposits**)
Your Social Security Number (**only last four required**)	**Your Home Telephone Number**

This authorization will remain in full force and effect until the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has received, at least two weeks before the scheduled payment date, written notification from me that I want to revoke this authorization.

Account holder must verify bank account data. Please attach a voided check.

SECTION 6—SURVIVING SPOUSE AGREEMENT AND SIGNATURE

I have read and understand the material describing the medical and dental benefits provided to me and if I had any questions, I have asked them of the Southern California Pipe Trades Administrative Corporation or Cigna and have received acceptable answers.

I understand that I will not be permitted to enroll in or change my dental plan until an open enrollment period, which are scheduled for October 1 through November 30 of each year.

I understand that if I do not enter a DHMO Office Number above, Cigna will initially assign me to a dentist based on my address. I will be permitted to change my dentist by contacting Cigna after I have enrolled.

IF I HAVE NOT ELECTED TO PAY VIA ACH IN SECTION 4, I HEREBY AUTHORIZE THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND TO DEDUCT FROM MY MONTHLY BENEFIT PAYMENTS SUCH SUMS AS ARE PERIODICALLY ESTABLISHED BY THE TRUSTEES OF THE SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND TO PROVIDE MEDICAL AND DENTAL OR MEDICAL ONLY COVERAGE UNDER THAT FUND. I understand that this amount will likely increase over time. I make this authorization voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly benefit payment or any portion thereof, to the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund. I understand that the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund has no right, enforceable against the Southern California Pipe Trades Retirement Fund, to any part of the monthly pension benefit.

I understand that if this authorization is revoked, I must provide an ACH Authorization Form so that my monthly medical and dental premiums can be deducted from my bank account. If I elect medical coverage only, I may send in a check. I also understand that failure to do so will result in the loss of medical and, if elected, dental coverage under the Pensioner and Surviving Spouses Health Fund. I understand that no other forms of payment will be accepted.

IF I ELECTED MEDICAL AND DENTAL COVERAGE AND AM NOT RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND, I HAVE COMPLETED THE ACH AUTHORIZATION IN SECTION 4 ABOVE.

X ______________________________ ______________________
Surviving Spouse Signature Date