SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email info@scptac.org | www.scptac.org

SURVIVING SPOUSE MEDICAL, DENTAL & VISION ENROLLMENT FORM

DEADLINE: 60 Days from Notice Date

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 at no cost (referred to as the "Special Extension Period"). 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 medical benefits under the terms of the Pensioner & Surviving Spouses Health Plan may also choose to purchase dental coverage in one of the two DeltaCare USA options as listed in Section 4 of this form, at the time he or she first becomes eligible for Plan benefits, and thereafter during an annual open enrollment period.

Vision: Surviving Spouses who are eligible for and elect medical benefits under the terms of the Pensioner & Surviving Spouses Health Plan may also choose to purchase vision coverage from Vision Service Plan (VSP) as listed in Section 4 of this form, at the time he or she first becomes eligible for Plan benefits, and thereafter during an annual open enrollment period. Once enrolled, vision coverage may only be terminated during an annual open enrollment period.

You may terminate 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 $135 per month (not including dental or vision); dental and vision premiums are listed below. If you elect dental and/or vision coverage, you must make 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. Your payment is due no later than 60 days from the loss of eligibility (including the Special Extension Period, if any).

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 the DeltaCare USA dental programs.)

SECTION 3—MEDICARE ELIGIBILITY (check one)

Are you eligible for Medicare? ☐ **Yes** ☐ **No** **(If yes, please attached a copy of your Medicare card to this form)**

SECTION 4—BENEFIT ELECTIONS

By checking the boxes below, I elect the following benefit(s):

Note: you must elect the Medical Benefit option in order to elect the vision and/or dental options.

MEDICAL BENEFIT ELECTION		VISION BENEFIT ELECTION		DENTAL BENEFIT ELECTION	
OPTION	COST PER MONTH	OPTION	COST PER MONTH	OPTION	COST PER MONTH
☐ MEDICAL BENEFIT	$135.00	☐ VSP CHOICE	$4.76	☐ DELTACARE USA HIGH	$17.03
				☐ DELTACARE USA MEDIUM	$11.70
				SIX-DIGIT DHMO FACILITY CODE	

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SECTION 5—ACH ELECTRONIC PAYMENT AUTHORIZATION

YOU SHOULD COMPLETE THIS SECTION IF YOU ARE ELECTING TO PAY FOR YOUR COVERAGE THROUGH AN AUTOMATIC, MONTHLY DEDUCTION THROUGH YOUR BANK ACCOUNT. HOWEVER, IF YOU ARE ELECTING DENTAL AND/OR VISION COVERAGE AND ARE **NOT** RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND OR YOUR PENSION BENEFIT IS NOT SUFFICIENT TO COVER YOUR PREMIUMS, 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 medical and, if elected, dental and vision 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**	**Your Social Security Number** (only last four required)

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, dental, and vision benefits provided to me and if I had any questions, I have asked them of the Southern California Pipe Trades Administrative Corporation, DeltaCare USA or VSP and have received acceptable answers.

I understand that if I make no election I will not have medical, dental or vision coverage.

I understand that I will not be permitted to enroll in or change my dental plan until the next open enrollment period.

I understand that if I do not enter a DHMO Facility Code in section 4, DeltaCare USA will initially assign me to a primary dentist based on my home zip code. I will be permitted to change my dentist by contacting DeltaCare USA after I have enrolled.

I understand that I will not be permitted to enroll in or, once enrolled, terminate my vision plan until the next open enrollment period.

IF I AM NOT REQUIRED TO COMPLETE SECTION 5, 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, IF ELECTED, DENTAL AND VISION 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, if elected, dental and vision 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 and vision coverage under the Pensioner & Surviving Spouses Health Fund. I understand that no other forms of payment will be accepted.

IF I ELECTED DENTAL AND VISION COVERAGE AND AM NOT RECEIVING A PENSION BENEFIT FROM THE SOUTHERN CALIFORNIA PIPE TRADES RETIREMENT FUND, I HAVE COMPLETED THE ACH AUTHORIZATION IN SECTION 5 ABOVE.

X
Surviving Spouse Signature _____ **Date**