Instructions for Non-Active Classification Self-Pay Application

1. Prior to completing the ***Non-Active Self-Pay Application*** process, please review your coverage options and call Participant Services with any questions.

2. When completing the ***Non-Active Self-Pay Application***, make sure Sections 1 – 6 are completed in full.

3. If you determine you qualify for non-active self-pay classification coverage, you must include a check for your first premium due with this application in the amount as calculated in **Section 4: Determine Your Monthly Premium Amount**. Payment must be received within 15 days of the date listed in **Section 2: First Premium Payment Due**.

4. Once you have completed the ***Non-Active Self-Pay Application***, mail the form and payment to:

   Mid-America Carpenters Benefits
   1419 Hampton Ave
   St. Louis, MO 63139

5. You will receive a letter confirming your non-active classification status once this application has been processed.

Should you have any questions, please contact our office Monday – Friday, 8 am – 4:30 pm:

By phone: (314) 644-4802
Toll-Free: (877) 232-3863
Email: health@macbenefits.org

Enclosures: Non-Active Self-Pay Application
Payment Authorization Form

Non-Active Classification Self-Pay Application

Reset

Mid-America Carpenters Regional Council Health Fund (Fund) / STLKC Southern Region

1419 Hampton Ave, St. Louis, MO 63139 | Phone: (314) 644-4802 | Fax: (314) 678-1110 | Email: health@macbenefits.org

SECTION 1: PARTICIPANT INFORMATION

Participant Last Name	Participant First Name	Participant MI	Date of Birth	Last 4 SSN

SECTION 2: PAYMENT INFORMATION

First Self-Payment Due Date (MM/01/YYYY)	First Non-Active Classification Coverage Month (MM/YYYY) (Month after first self-pay due date)

SECTION 3: QUALIFICATION VERIFICATION *Contact our office if you need assistance with answering these questions.*

A.	Do you currently have coverage through the Carpenters Health Plan under the Active Classification?	☐ Yes ☐ No
B.	Are you drawing a pension or totally disabled from working in the trade?	☐ Yes ☐ No
	Pension Fund: ☐ St. Louis ☐ Kansas City ☐ Kansas Building Trades ☐ Geneva	
C.	Are your union dues current with your Local?	☐ Yes ☐ No
	Local # *For questions about Local status, call (314) 644-4800 or (800) 332-7188*	
D.	Do you have at least 3 years of Active Classification* coverage within the last 5 years under the Fund?	☐ Yes ☐ No
E.	Do you have at least 10 years of Active Classification* coverage under the Fund during your career?	☐ Yes ☐ No

***Active Classification includes hours-based eligibility, Minimum/Difference Payments and COBRA.**

If you answered **YES** to all the questions above, you qualify for this Non-Active Classification coverage. **Proceed to Section 4.**

If you answered **NO** to any question above, you do not qualify for Non-Active Classification coverage. If you are/were working for a union employer in a non-bargaining position and you are losing coverage with that employer, you may still qualify. Contact our office for details.

SECTION 4: DETERMINE YOUR MONTHLY PREMIUM AMOUNT *The questions below will assist you in calculating your monthly rote.*

Medicare Participants Coverage for Medicare eligible dependents is provided through UnitedHealthcare's Medicare Advantage Plan *You **must** have both Medicare Part A & B.*	Are you (participant) eligible for Medicare? Enter **$287** for YES Enter **$715** for NO	**$**
	Do you want Single or Family Coverage? Enter **$0** for Single For Family, enter **$287** for one dependent eligible for Medicare or enter **$715** for NO dependents on Medicare	**$**
	Do you want Dental Coverage? If NO, enter **$0**. If YES, enter **$35** for Single or enter **$70** for Family.	**$**
	Add the three lines above together for your Monthly Premium Amount	**$**

SECTION 5: FAMILY COVERAGE ONLY *If you have two or more dependents, complete on a second page.*

Spouse Name	Date of Birth	Eligible for Medicare? ☐ Yes ☐ No If YES, attach a copy of spouse's Medicare card.	Other Group coverage? ☐ Yes ☐ No
Dependent Name	Date of Birth	Eligible for Medicare? ☐ Yes ☐ No If YES, attach a copy of dependent Medicare card.	Other Group coverage? ☐ Yes ☐ No

SECTION 6: SIGNATURE

I hereby authorize either the Carpenters Pension Trust Fund of St. Louis **or** the Carpenters Pension Trust Fund of Kansas City to deduct the appropriate premium(s) from my monthly pension benefit for the coverage under the MACRC Health Fund Non-Active Classification Benefits ("Health Fund") that I have elected. I understand that premium rates may increase annually. If premiums increase under the Health Fund, the Pension Fund is authorized to withhold the increased premium amount from my pension payment.

I have answered all the above questions to the best of my knowledge and by signature, I am authorizing the Health Fund to contact the Regional Council and my pension fund to verify the information I provided. I also understand there are no Short-Term Disability benefits while covered in this Non-Active Classification.

X

Participant Signature **Date**

Self-Payment Authorization Form

Mid-America Carpenters Regional Council Health Fund (Fund) / STLKC Southern Region
1419 Hampton Ave, St. Louis, MO 63139 | Phone: (314) 644-4802 | Fax: (314) 678-1110 | Email: health@macbenefits.org

SECTION 1: PARTICIPANT INFORMATION

Participant Last Name	Participant First Name	Participant Middle Initial	Last 4 SSN

To the Trustees of the Mid-America Carpenters Regional Council Health Fund (Fund), I hereby request that my health and welfare contributions, payable by me, be processed through the following payment option:

SECTION 2: PAYMENT OPTIONS

Option 1: Member Portal	To set up a recurring payment using your bank account or credit card, please set up an account/sign into our Member Portal at **laborfunds.org /member-portal** or scan the QR code on the right.
Option 2: (Preferred) **Pension Benefit Deduction**	To set up a recurring payment using your pension benefit deduction or bank account, complete this section and mail this form to the address at the top of this form. **Manual Payments should be made until Pension Deduction is confirmed.** *Continue to pay your monthly premiums until you receive confirmation of your automatic payment effective date.* ☐ **Pension Benefit Deduction** ☐ St. Louis Pension Plan ☐ Kansas City Pension Plan Net Monthly Pension Amount* (after income tax and union dues deductions, if applicable): $ **Net Monthly Pension Amount must be equal to or greater than requested premium amount.* **Note: If you have a Geneva or KBT Pension or are a COBRA participant, this option is not available to you.**

SECTION 3: AUTHORIZATION AND SIGNATURE

I understand that the Trustees have discretion whether to comply with this request. I understand I may cancel or change this authorization for payment from the account selected above by written notice to the Plan at least ten days prior to the first day of the month for that month's payment processing. I certify this authorization will remain in effect until either (1) I provide written notice to cancel this request, or, in the case I have elected Pension Deduction above, (2) my health and welfare benefit is greater than my pension benefit and therefore pension deduction is no longer possible. My signature on this authorization indicates that I authorize the verification of the above information by the financial institution of the Plan's Trustees or their designated representative. I consent that a copy of this authorization may be considered as valid as the original.

I also understand the date the deduction will begin, and the current rate will be verified with the Benefit Plans Office. Also, Option #2 is not possible if Health and Welfare contribution exceeds monthly Pension Benefit.

X _____ _____

Participant Signature **Date**

Submit completed Enrollment Form with copies of all required documents:

- **Upload** securely to the Member Portal: **laborfunds.org/member-portal**
- By **mail** to the address at the top of this form, Attn: Participant Services
- By **fax** to the fax number at the top of this form

FOR OFFICE USE ONLY

Rate Type	Amount	Payment Effective Date	Auth By & Date