CMTA-IAM JOINT RETIREE HEALTH & WELFARE PLAN

4160 DUBLIN BOULEVARD SUITE 400 • DUBLIN, CA 94568-7756
TELEPHONE (866) 889-7313 FAX (925) 833-7300
www.aitrustfunds.org

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

The DeltaCare Dental Plan & Hearing Aid Benefit is administered through the Kaiser Senior Advantage Plan

Completed form must be submitted to: CMTA-IAM Joint Retiree Health & Welfare Plan
4160 Dublin Blvd, Suite 400
Dublin, CA 94568

DeltaCare Dental Plan & Hearing Benefit

_____ I wish to enroll in the DeltaCare Dental Plan & Hearing Aid Benefit. I am on Medicare and enrolled in Kaiser Senior Advantage. I understand that my Retiree Health & Welfare self-payment will increase beginning coverage for next month and the subsequent month of coverage. I have enclosed the payment for the benefit that will be in effect the next month.

_____ I wish to enroll **myself and my spouse** in the DeltaCare Dental Plan & Hearing Aid Benefit. We are both on Medicare and enrolled in Kaiser Senior Advantage. I understand that my Retiree Health & Welfare self-payment will increase beginning coverage for next month and the subsequent month of coverage. I have enclosed the payment for the benefit that will be in effect the next month.

Member Last Name, First Name (Please Print)	Date of Birth	Social Security Number
Spouse Last Name, First Name (IF APPLICABLE)	Date of Birth	Social Security Number
Street Address		
City, State and Zip Code	Telephone Number	

I UNDERSTAND THAT I MUST BE ELIGIBLE IN ACCORDANCE WITH PLAN RULES FOR COVERAGE. IF I AM ELIGIBLE AND HAVE CHOSEN TO MAKE MY RETIREE HEALTH & WELFARE PAYMENTS THROUGH PENSION DEDUCTION OR ACH TRANSFER, I HEREBY AUTHORIZE THE TRUST FUND TO CHANGE MY PENSION DEDUCTION OR ACH TRANSFER TO THE REQUIRED MONTHLY AMOUNT TO PAY THE ADDITIONAL MONTHLY AMOUNT OWED TO THE TRUST DUE TO MY ELECTION OF THE DELTACARE & HEARING AID BENEFIT.

I UNDERSTAND THAT THE CMTA-IAM JOINT RETIREE HEALTH & WELFARE TRUST FUND HAS NO ENFORCEABLE RIGHT IN, OR TO MY PENSION PLAN BENEFIT PAYMENT OR PORTION THEREOF, EXCEPT TO THE PAYMENTS ACTUALLY RECEIVED BY THE PLAN PURSUANT TO THIS AUTHORIZATION. I ALSO UNDERSTAND THAT IF I CANCEL MY ENROLLMENT IN THE DELTACARE DENTAL PLAN & HEARING BENEFIT, I FORFEIT MY RIGHT TO REENROLL IN LATER.

Signature	Date Signed