TIER III Enrollment Form: 7/01/2019 to 6/30/2020

DEADLINE: Please complete & return with your payment no later than June 17

I. <u>Tier III Coverage</u>

Please put a check mark in the box next to the type of coverage you would like to elect.

| Coverage Type | Quarterly | | Quarterly with Wellness Incentive* | | Full Year | Full Year with Wellness Incentive* |
|--------------------|----------------------|---------------------|---------------------------------------|---------------------|---------------------|------------------------------------|
| | 7/01/19- 12/31/19 | 1/01/20- 6/30/20 | 7/01/19- 12/31/19 | 1/01/20- 6/30/20 | 7/01/19- 6/30/20 | 7/01/19- 6/30/20 |
| Participant | \$512 | \$520 | \$412 | \$420 | \$2,064 | \$1,664 |
| Participant plus 1 | \$630 | \$641 | \$530 | \$541 | \$2,542 | \$2,142 |
| Family | \$749 | \$762 | \$649 | \$662 | \$3,022 | \$2,622 |

^{*}Please see the back of this page for details on the Wellness Incentive.

| Name: | Social Security Number: | | | | | | | | |
|--|--|-----------------------|------------------|----------------|--|--|--|--|--|
| Address: | | | | | | | | | |
| Street Address / A | Apt No. | City | State | Zip Code | | | | | |
| Date of Birth: | Home Phone: | Ce | Cell Phone: | | | | | | |
| Email Address: | | | | | | | | | |
| Spouse Name: | umber: | | | | | | | | |
| Date of Marriage: | Spous | Spouse Date of Birth: | | | | | | | |
| Dependent Information | | | | | | | | | |
| | au wich to cover offective | July 1 2010 V | ou must attach e | onics of hirth | | | | | |
| lease list the dependents you wish to cover effective July 1, 2019. You must attach copies of birth ertificates, marriage certificates, and social security cards for all new dependents listed. | | | | | | | | | |
| certificates, marriage certi | ilicates, and social secul | ity cards for all | new dependent | s iistea. | | | | | |
| Dependent's Name | Date of Birth | Social Secui | rity No. Relatio | nship | | | | | |
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| Chack boro if you wish | Check here if you wish Welfare coverage for yourself only. | | | | | | | | |
| Check here if you wish | i wellare coverage for y | oursen only. | | | | | | | |
| Payment Information | | | | | | | | | |
| | | | | | | | | | |
| All fund participants must se | • • | | | | | | | | |
| person at the Fund Office, o | | | • • | | | | | | |
| ou may make your self-pay premium payment quarterly, every 6 months, or pay the entire year in advar | | | | | | | | | |
| lease see the rates in Section I above. | | | | | | | | | |
| | | | | | | | | | |
| ticipant Signature | | Date | | | | | | | |
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2019 Wellness Incentive Details

The Wellness Incentive is a **\$400 per year** (\$100 per quarter) reduction in your self-pay premium which you earn by completing certain health-related goals each year you are a participant in the Welfare Fund. To continue receiving the incentive starting **1/01/20**, you need to meet the health-related goal during **2019**.

To qualify for the Wellness Incentive program, which **begins on January 1, 2020**, <u>active participants and their covered spouses</u> must have a Wellness Exam (what we used to call an annual physical) during **calendar year 2019**. (Please note that the incentive program is for <u>active</u> participants and is not available to retirees.)

Please note that to ensure you receive your credit at the time your self-pay premium payment is due on or before 1/01/2020, **please have your exam completed by 10/31/2019**. While we will certainly honor exams done in November and December, you will either need to provide written proof of the exams at the time of payment, or pay the regular self-pay premium with the understanding that we will credit you for the 1/01/20 incentive the following quarter.

The reason this incentive is being offered is that the Trustees believe that it is vitally important we all see a doctor at least once a year. Early detection of chronic diseases like high blood pressure or diabetes generally results in better outcomes for patients, and lower costs for treatment. Annual Wellness visits help ensure that we receive recommended screenings and care, and that when we do get sick, we have an ongoing relationship with a doctor and don't end up in an emergency room. (Improper use of ER's is a huge area of waste.) We believe that this is a win-win for both you and the Fund as a whole.

If you don't currently have a relationship with a doctor, you can call the Friedman Health Center at (212)489-1939 to schedule a Wellness Exam. Friedman is Local One's "Medical Home" and there is NO CO-PAY for any primary care visit if you have Tier I, II or III coverage. They are located at 729 Seventh Avenue between 48th and 49th streets.

So please, if you don't have a regular annual Wellness check-up, make sure you start in 2019. Please call the Fund Office if you have any questions about the details of the incentive program.