PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

EXTENDED COVERAGE PROGRAM
Election Form

Please complete this form and return it to the Health Fund office within 45 days of this letter.

Participant's name _____ Unique ID # _____

Street Address _____ Apt# _____ (Area Code) Phone # _____

City _____ State _____ Zip _____

CHECK ONE: ❑ Single ❑ Married ❑ Separated ❑ Widow ❑ Divorced

If you are married, please indicate the marriage date (____/____/____)

If Medicare covers you or your spouse, check the appropriate box.

❑ Self ❑ Spouse

PLEASE DO NOT RETURN THIS ELECTION FORM IF YOU ARE NOT CHANGING YOUR PLAN.

❑ I have read the above information and wish to change my plan under the Extended Coverage Program.

_____ _____
Participant's Signature Date

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www.wgaplans.org

EXTENDED COVERAGE PROGRAM
ELECTION FORM

Indicate the plan you wish to be covered under. **Please choose carefully!** Your selection will remain in effect for the duration of your coverage under the Extended Coverage Program in 2018:

___**Plan 1** Medical/Hospital, Delta Dental (DPO), RX, Vision, Wellness **2.50 pts/qtr**

___**Plan 2** Medical/Hospital, Delta Care (DHMO), RX, Vision, Wellness* **2.50 pts/qtr**
If you want to choose this plan, please contact our office immediately to request the directory and enrollment form.* **This plan is only available to California residents only.

___**Plan 3** Medical/Hospital **ONLY** $750 Deductible* **Low Option Plan** **1.50 pts/qtr**
Go to **wgaplans.org, click on the Health Fund Benefit Tabs, then Low Option Plan to view the benefits changes*

The above points will be deducted from your Extended Coverage Program point balance on a quarterly basis**.**

In the box below list all persons (including yourself) to be covered under the Extended Coverage Program:

Name	Date of Birth	Relationship	Other Coverage

(If necessary use another sheet and attach for additional dependents.)

Persons listed above will only be covered if they meet all of the eligibility requirements for this coverage as set forth in the Fund's Summary Plan Description as well as the Extended Coverage Program Document.