BAKERY AND CONFECTINERY UNION AND
INDUSTRY INTERNATIONAL HEALTH BENEFITS FUND

10401 Connecticut Avenue ● Kensington, Maryland 20895-3960

RETIREE HEALTH BENEFITS W-1 AND W-102

W-1 Coverage – Eligibility to Receive W-1 Coverage

Pensioners whose employer provides for W-1 coverage in their Collective Bargaining Agreement, who have worked the required 504 hours under the Plan, and who have met the required eligibility rules as established by the Trustees will be eligible to receive W-1 coverage if they pay monthly premiums. W-1 coverage is also available for dependents.

The cost of the coverage will be established by the Trustees of the Fund. The cost is based on the age of the individual(s) covered under the W-1 Plan and the employer's continued participation in the W-1 Plan. There is a different cost for individuals under age 65, and for individuals age 65 and over or covered by Medicare.

When to Enroll: If you are **65 years of age or older** on your effective date of pension, you must opt to take the W-1 or W-102 coverage at the time you receive your first monthly pension check or within 90 days after your coverage ends under any other group health plan including continuation coverage under COBRA. **If you do not sign up for the W-1 or W-102 coverage at one of these times you will not be eligible to enroll in W-1 or W-102 at any later date.**

If you are **under age 65**, you must elect to take the W-1 coverage at any of the following four times: (a) at the time you receive your first pension check; (b) within 90 days after your coverage under any other group health plan ends (including continuation coverage under COBRA); (c) during the 90 days following the date on which you enroll in Medicare Part A and B prior to age 65 and (d) when you reach age 65. An enrollment form will be sent to you prior to your 65th birthday, at which time you can accept or reject the W-1 or W-102 coverage at age 65. If you do not enroll in the W-1 or W-102 Plan at one of these four times you will not be eligible to enroll at any other date.

Please note: Under options (a), (b) and (c) it is your responsibility to contact the Fund within 90 days of the event and request coverage. If you fail to notify the Fund within the 90-day period, you cannot enroll in the W-1 coverage until age 65. Enclosed is a book, which contains the Summary Plan Description and Rules and Regulations of the W-1 Plan. For enrollment rules, please refer to Article 2 and Article 3, Sections 3.2(b)(2) and 3.3.

Generally you must enroll dependents at the same time that you enroll yourself. There are several exceptions to this rule. They are listed in Section 2.2(d) of the enclosed book.

RETIREE HEALTH ENROLLMENT FORM

COVERAGE FOR YOURSELF

Option 1 _____ - Plan W-1 Basic
Option 2 _____ - Plan W-1 Basic and Supplemental Major Medical
Option 3 _____ - W-102 Plan – You must be 65 or older or on Medicare Part A & B
Option 4 _____ - I reject coverage for myself (if you check this option you cannot cover your spouse or dependent(s)

COVERAGE FOR SPOUSE

Spouse's Name	Social Security No.	Date of Birth
______________________	____________________	____________________

Option 1 _____ - Plan W-1 Basic
Option 2 _____ - Plan W-1 Basic and Supplemental Major Medical
Option 3 _____ - W-102 Plan – Spouse must be 65 or older or on Medicare Part A & B
Option 4 _____ - I reject coverage for spouse

COVERAGE FOR DEPENDENT CHILD (CHILDREN)

Child's Name	Social Security No.	Date of Birth	Relationship
___________________	_________________	______________	________________
___________________	_________________	______________	________________

Option 1 _____ - Plan W-1 Basic
Option 2 _____ - I reject coverage for dependent(s)

PAYMENT OPTION: Place an **X** next to the statement which advises the Fund how you will make payment.

_____ Do not deduct monthly premiums from my pension check. I will make payments myself.

_____ I, (name) _____________________________________, authorize deductions of the appropriate amounts from my pension check for the above option(s) I have chosen, until I revoke this authorization in writing. If the premium increases, I further authorize deduction of the new amount as determined by the Trustees until I revoke my authorization in writing.

______________________________________ ________________________________
Signature Date

MAIL TO:
B&C International Pension Fund
10401 Connecticut Avenue, Suite 310
Kensington, MD 20895-3960