BAY AREA DELIVERY DRIVERS SECURITY FUND

4160 DUBLIN BLVD SUITE 400, DUBLIN, CA 94568-7756
TOLL FREE (800) 654-1824 . FAX (925) 833-7301

APPLICATION FOR RETIREE BENEFITS

Name: ______________________ S. S. #: ______________________

Address: ______________________ Phone #: ______________________

______________________ Birth Date: ______________________

Employer: ______________________ Retirement Date: ______________________

Show the following information with regard to any dependents, including your spouse and unmarried dependent children less than nineteen (19) years of age or full-time students to age twenty-four (24) residing with you and wholly dependent upon you for financial support.

Full Name: ______________________

Sex: ________ Relationship: ______________ Birth Date: ______________

Full Name: ______________________

Sex: ________ Relationship: ______________ Birth Date: ______________

Full Name: ______________________

Sex: ________ Relationship: ______________ Birth Date: ______________

On what basis did you obtain your pension? AGE ☐ or DISABILITY ☐ If you checked Disability you must attach a copy of your Social Security Award letter that shows the beginning date of your disability. You will be eligible for Medicare at age 65 if NOT disabled OR 24 months after the date you are eligible to receive Social Security Disability Benefits due to disability. IMPORTANT: You MUST sign up for both Part A and Part B Medicare at the time you are eligible. If you fail to sign up for Part B Medicare, Indemnity Plan benefits will be paid as if you had signed up for Part B. As a result your benefits will be substantially reduced. If you are a Kaiser member you will be enrolled in the Indemnity Plan with reduced benefits. *This requirement also applies to your spouse or other dependents.* Are you or any dependents eligible for Medicare at this time? ☐ Yes ☐ No If Yes, attach a copy of card.

DO YOU OR ANY OF THE DEPENDENTS LISTED ABOVE HAVE OTHER GROUP COVERAGE? IF YES, PLEASE COMPLETE BELOW:

Name of covered person (s):______________________

Insurance Carrier:______________________Group #______________

Effective date of coverage:______________________

Employer: ______________________

LIFE INSURANCE BENEFICIARY DESIGNATION:

I hereby designate ______________________, whose address is ______________________ as my beneficiary for my life insurance provided for retired employees under the Bay Area Delivery Drivers Security Fund.

Dated this ____________day of ____________ 20____ at ______________________

Signed: ______________________Date:______________

MONTHLY CO-PAYMENT: If you retire on or after 7/1/04 the following monthly co-payment is required. Please check the applicable rate below based on the age of the retiree (not spouse). Payment is due on the first day of each calendar month. If you fail to make the payment within thirty days of the date it is due, your coverage will be terminated and cannot be reinstated.

Under age 55: $150/mo __________ Age 55 through 59: $100/mo__________

Age 60 through 64: $50/mo__________ Age 65 and over (or Medicare eligible): No co-payment due________

SEE REVERSE

Retiree Application

TO BE COMPLETED BY TEAMSTERS UNION LOCAL SECRETARY-TREASURER

Member of Union Local #__________ from ___________ to ______________

Pension or Social Security Award from ________________________________
(a copy of this award must accompany this application)

Verified by: ____Secretary-Treasurer

TO BE COMPLETED BY THE ADMINISTRATION OFFICE:

Period of Eligibility: From ________________________*to* _____________________

Employed by:_____________________from_________________to_____________

Verified by:____