MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

WIDOW ENROLLMENT FORM

Please complete the following information:

YOUR NAME: _____ WIDOW OF: _____

SS #: _____ SS #:_____

ADDRESS: _____ DATE DECEASED: _____

_____ LOCAL UNION #: _____

PHONE: _____ YOUR DATE OF BIRTH: _____

DEPENDENT CHILDREN:

NAME: _____ BIRTHDATE: _____ SS #: _____

NAME: _____ BIRTHDATE: _____ SS #: _____

NAME: _____ BIRTHDATE: _____ SS #: _____

You may continue in the WIDOW PLAN until you reach the age of 65, become Medicare eligible or remarry.

RATE: **$290/month** (subject to change with contribution rate increases)

YOU HAVE TWO OPTIONS FOR REMITTING PAYMENTS FOR THE WIDOW PLAN:

Option 1: You may remit a check each month to the Health Plan and you may pay up to six (6) months in advance. If you choose this option, please include your 1st payment with the Enrollment Form. Make checks payable to: Michigan Electrical Employees' Health Plan or (MEEHP).

Option 2: You may elect to have your payment deducted from your husband's Special Fund account until the account is exhausted.

_____
WIDOW'S SIGNATURE

_____
DATE

SPECIAL FUND DEDUCTION AUTHORIZATION

I HEREBY AUTHORIZE THE HEALTH PLAN TO DEDUCT FROM MY HUSBAND'S SPECIAL FUND ACCOUNT THE AMOUNT REQUIRED EACH MONTH TO MAINTAIN ELIGIBILITY THROUGH SELF-PAYMENT AS A WIDOW OR SUPPLEMENT TO MEDICARE UNTIL HIS SPECIAL FUND BALANCE IS EXHAUSTED.

_____	_____	_____
NAME (Print or Type)	WIDOW'S SIGNATURE	DATE

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION
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