USW RETIREES OF THE DANA CORPORATION HEALTH CARE TRUST

FUND ADMINISTRATION OFFICE

60 Blvd. Of the Allies, 5th Floor
Pittsburgh, PA 15222
Toll Free: 1-(866)-201-1344
Fax: 412-224-4465

2013 ENROLLMENT ELECTION FORM

Type or print all information in the **Retiree Information** and **Medical Election** Sections below. Contact the VEBA Fund Office at 866-201-1344 with any questions. Send completed form to the address indicated at the top of this form. For Split coverage (One Medicare and One Non-Medicare) please check both individual's Medical Elections in the boxes below.

COVERED PARTICIPANTS INFORMATION:

Name	*Social Security Number*	*Date of Birth*	*Relationship*	Medicare Eligible**
			Member	❑☐ **Yes** ❑☐**No**
			Spouse	❑☐**Yes** ❑☐**No**
			Dependent	❑☐**Yes** ❑☐**No**
			Dependent	❑☐**Yes** ❑☐**No**

***** If Medicare eligible, please submit a copy of your Medicare cards with this Enrollment Form.***

Address:			
City:	*State:*	*Zip code:*	*Phone:*

MEDICAL ELECTION:

Non-Medicare Eligible

❑ Highmark BCBS PPO
❑ Member ❑ Spouse ❑ Other (dependent)

Medicare Eligible *(you may also be required to complete the carrier enrollment form)

❑ Freedom Blue PPO Medicare Advantage
❑ Member ❑ Spouse ❑ Other (dependent)

❑ SeniorBlue PPO –Capital BCBS (21 Counties in PA) ****See attached letter for Counties covered.***
❑ Member ❑ Spouse ❑ Other (dependent)

❑ USW Retiree VEBA Medicare Supplement (All States)
❑ Member ❑ Spouse ❑ Other (dependent)

I understand that by electing this coverage, I am responsible for paying any applicable monthly premium to the USW Retiree VEBA. I understand that I may cancel this coverage at any time without guarantee of re-enrollment on a future date.

Signature:______________________________ Date:__________________

WAIVER OF COVERAGE:

❑ I do not wish to elect coverage through the VEBA.

I understand that if I elect to waive or terminate coverage with the VEBA I will not be permitted to re-enroll at a later date, unless I experience involuntary loss of other group health insurance coverage. I will also lose my right as a retiree to the Death Benefit.

Signature:______________________________ Date:__________________