Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Retiree Program Application (Pre-Medicare)

SECTION 1: MEMBER INFORMATION

Member's Full Name	Date of Birth / /	SSN

Mailing Address	City	State	Zip Code

Primary Phone ( )	E-mail Address

Date of Retirement / /	Most Recent Employer	Local Union #

Number of years with last employer?	Number of years with Teamsters Union?

Will you be employed after retirement? ❑ Yes ❑ No If yes, number of hours will you work per week:

Are you covered by Medicare: ❑ Yes ❑ No	If yes, effective date(s) of Medicare **Part A**: / / Medicare **Part B**: / /

SECTION 2: SPOUSE INFORMATION (complete only if spouse will be covered on the retiree plan)

Spouse's Full Name	Date of Birth / /	SSN

Primary Phone ( )	E-mail Address

Is spouse covered by Medicare: ❑ Yes ❑ No	If yes, effective date(s) of Medicare **Part A**: / / Medicare **Part B**: / /

Is spouse currently employed: ❑ Yes ❑ No If yes, number of hours worked per week*:

Spouse's Employer	Phone Number ( )

Does spouse have access to employer sponsored health and welfare coverage: ❑ Yes* ❑ No

*Note**:** In order to be eligible for a retiree benefit; spouse may **not work more than 30 hours per week** or **have access to other coverage**. See Spouse's Attestation below.

SECTION 2a: SPOUSE ATTESTATION (to be completed by the spouse if accessing retiree coverage)

I, ________________________________ (spouse's full name) certify that the information provided regarding myself is complete and accurate to the best of my knowledge. I attest that I do not work more than 30 hours per week nor do I have access to health and welfare benefits through my employer.

- I understand that Allegiant Care reserves the right to conduct periodic audits to confirm that I do not work more than 30 hours per week or have access to employer sponsored coverage.
- I understand that I must notify Allegiant Care immediately should my current employment status change.
- I understand that if Allegiant Care provides coverage for which I am not eligible, I will be responsible for any expenses paid by Allegiant Care during the time that I was not eligible.

Spouse's Signature: **Date:**

SECTION 3: DEPENDENT CHILD INFORMATION (complete only if dependent(s) will be covered on the retiree plan)

1. Dependent's Full Name		Date of Birth / /	SSN
Mailing Address (if different)	City	State	Zip Code
Prime Phone Number ( )	E-mail Address		

2. Dependent's Full Name		Date of Birth / /	SSN
Mailing Address (if different)	City	State	Zip Code
Prime Phone Number ( )	E-mail Address		

3. Dependent's Full Name		Date of Birth / /	SSN
Mailing Address (if different)	City	State	Zip Code
Prime Phone Number ( )	E-mail Address		

Note: An eligible dependent between the ages of 19 and 25 **must be enrolled as a full-time student at an accredited post-secondary school or college.** Proof of full-time student status must be submitted with this form.

SECTION 4: CERTIFICATION & AUTHORIZATION

I hereby certify the information provided on this form is complete and accurate to the best of my knowledge. I authorize any person or organization in possession of benefit information concerning myself and/or dependents to furnish or obtain verification of coverage or other benefit information from Allegiant Care.

Member's Signature: ______________________________ **Date:** ____________

Return your completed form to the mailing address noted on page 1.
You may also fax it directly to 603-666-4477 or email retirees@myallegiantcare.com.
Retain a copy for your records.