

East Bay Drayage Drivers Security Fund

Local 70 Health & Welfare Office
400 Roland Way
Oakland, CA 94621

Phone (855) 263-7242



Phone (925) 954-1439

Re: Election of Retirement Benefits

Dear Retiring Participant:

To apply for retirement health and welfare benefits under the East Bay Drayage Drivers Security Fund Retiree Plan, please complete the enclosed application and return it to the Administration Office with a copy of your **Certification of Retirement Benefit** from the Western Conference of Teamsters Pension Trust within 90 days of receiving your Pension Award Certificate. Late applications will be accepted only upon approval of the Trustees for good cause. The WCT Pension Trust can be reached at (800) 845-4162.

NOTE: If you're unable to provide your Certificate of Retirement Benefits at this time, you will need to provide at a later date when available.

ELIGIBILITY REQUIREMENTS

Service Requirements are as follows:

You must have been covered as an active employee under the East Bay Drayage Drivers Security Fund:

- for at least 60 of the 84 months immediately preceding your retirement date* including at least 12 months of the 24 months immediately preceding your retirement date*
and
- had at least 5 years of coverage under the active employee Plan.

If you do not meet the specific qualifications described above, you still meet the service requirement if you have been covered as an active employee under the East Bay Drayage Drivers Security Fund:

- for a total 180 months or more within the most recent 240 months prior to your retirement date* including at least 12 months of the 24 months immediately preceding your retirement date.*
or
- for at least 300 months, including at least 12 months of the 24 months immediately preceding your retirement date.*

Retirees with less than 5 years of coverage are not eligible to participate in the retiree plan.

* Your "retirement date" is the date of your retirement as determined by the Western Conference of Teamsters Pension Plan. As of August 1, 2003, the date you apply for retiree health benefits is no longer relevant to whether you meet the eligibility tests.

ELIGIBILITY REQUIREMENTS (continued)

Medicare Requirements (for all current and future Medicare-eligible Retirees and Dependents)

If you or any of your eligible dependents become eligible for Medicare, Fund policy dictates that you must:

- enroll in one of the two Medicare Supplement plans offered by the Fund, and
- enroll in Medicare Parts A and B.

Enrollment in one of the two Medicare Plans is not optional. *If you do not enroll when you become Medicare eligible your coverage under the Fund will be terminated.*

PLANS FOR RETIREES

Non-Medicare Retirees

- Anthem Blue Cross Self-Funded PPO Plan with Rx benefits through Elixir
- Kaiser HMO Plan with Rx benefits through Kaiser
- Anthem Blue Cross HMO plan with Rx benefits through Anthem Blue Cross

Medicare-Eligible Retirees

- Kaiser Senior Advantage Plan with Rx benefits through Kaiser
- TEAMStar Medicare Supplement Plan F with Rx benefits through Teamsters Plus

Until the next "Open Enrollment" period starting July 1, you will have the Retiree version of the same plan that you now have, unless you have become Medicare eligible and are enrolled as an Active in either the Anthem Blue Cross Self-Funded PPO Plan or the Anthem Blue Cross HMO plan.

You can change to a different plan during "Open Enrollment" held during the month of July each year. The effective date of any change will be the following August 1. A letter will be sent to you prior to Open Enrollment and descriptive literature about the plans is always available on the East Bay website www.ebddsfs.com, from the Administration Office, or from the Local 70 Health & Welfare Office at (510) 636-0381.

PAYMENTS

On the following page you will find monthly contribution rates. Please remember that if you are now married and you elect single coverage now, **you will NOT have the option in the future to add your spouse or dependents.**

Your monthly payments will be due on the 1st of each month and delinquent on the 10th. However, do not send a payment now. **Your first payment will be due effective with your retirement effective date through Western Conference Teamsters Pension Trust, or when your active benefits cease.** Accounts delinquent 90 days or more will be terminated.

MONTHLY CONTRIBUTION RATES

PLEASE CIRCLE THE APPROPRIATE CONTRIBUTION RATE, (Based on your age, your years of coverage under the East Bay Drayage Drivers Security Fund and the Plan you are now covered under.) **The administrator will not advise you of rate changes when you reach age 62 or 65. It's your responsibility to send in the correct amount when you reach 62 or 65 or become eligible for Medicare.**

PLANS: In the Rate Chart below, "HMO" means Kaiser or Anthem Blue Cross and "PPO" means the Anthem Blue Cross Self-Funded Plan. Remember to check the box advising us if you elect coverage for yourself only, or coverage for yourself and/or your spouse and/or your eligible dependent(s). **IMPORTANT:** If you are now married and you elect single coverage now, you **will NOT** have the option in the future to add your spouse or dependents.

COST: The Contributions in the chart below are for the Retiree only. **If you cover your spouse, the amounts shown will be doubled.** There is no charge for eligible dependent children. **If your spouse has active coverage through their employer, please check with your Health and Welfare representative about your coverage options.**

- I elect coverage for: myself only
 myself & my spouse
 myself, my spouse & my dependent child/children
 myself & my dependent child/children

YEARS COVERED UNDER EBDDSF	Under Age 62		Age 62 to 64		Age 65 & Over and Medicare Eligible, and/or Medicare Eligible due to Disability (Regardless of Age)		
	HMO Kaiser or Anthem Blue Cross	PPO (Self-funded) Anthem Blue Cross	HMO Kaiser or Anthem Blue Cross	PPO (Self-funded) Anthem Blue Cross	HMO Kaiser Senior Advantage	PPO TEAMSTAR (Transfer from HMO)	PPO TEAMSTAR (Transfer from PPO)
5-9	\$285	\$379	\$280	\$375	\$180	\$151	\$224
10 to 19	\$256	\$338	\$256	\$338	\$165	\$140	\$205
20 to 29	\$256	\$338	\$231	\$313	\$155	\$130	\$195
30 to 39	\$231	\$313	\$194	\$275	\$130	\$105	\$170
40 Plus	\$194	\$275	\$163	\$244	\$100	\$75	\$125
Orphan Retirees*	***	***	***	***	***	***	***

*** An Orphan Retiree is a retiree whose company has gone out of business. Contact the Administration Office for the rate that would apply to you.

RETURN THIS FORM TO: EAST BAY DRAYAGE SECURITY FUND
 Local 70 Health & Welfare Office
 400 Roland Way, Oakland, CA 94621

RETIREE CO-PAYMENT QUESTIONNAIRE

Please print all information clearly

MEMBER INFORMATION

Name _____ Birth Date _____ / _____ / _____
Month Day Year

Social Security Number _____

Phone # _____

My effective date with Medicare was (Part A) _____ (Part B) _____
Date Date

or will be (Part A) _____ (Part B) _____
Date Date

I retired from _____ on _____
Last Employer

_____ . At that time, I had been covered by the East
Last Date Worked

Bay Drayage Drivers Security Fund since _____ / _____ .
Month Year

Note: You must fill in all blanks. If you do not have exact information, approximate and check this box. Approximate

SPOUSE INFORMATION

Name _____ Birth Date _____ / _____ / _____
Month Day Year

Social Security Number _____

My effective date with Medicare was (Part A) _____ (Part B) _____
Date Date

or will be (Part A) _____ (Part B) _____
Date Date

Note: You must fill in all blanks. If you do not have exact information, approximate and check this box. Approximate

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RETIREE CO-PAYMENT QUESTIONNAIRE

Please print all information clearly

DEPENDENT INFORMATION

Name _____ Birth Date _____ / _____ / _____
Month Day Year

Social Security Number _____

My effective date with Medicare was (Part A) _____ (Part B) _____
Date Date

or will be (Part A) _____ (Part B) _____
Date Date

Note: You must fill in all blanks. If you do not have exact information, approximate and check this box. Approximate

DEPENDENT INFORMATION

Name _____ Birth Date _____ / _____ / _____
Month Day Year

Social Security Number _____

My effective date with Medicare was (Part A) _____ (Part B) _____
Date Date

or will be (Part A) _____ (Part B) _____
Date Date

Note: You must fill in all blanks. If you do not have exact information, approximate and check this box. Approximate

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400 Roland Way, Oakland, CA 94621

DIRECT DEBIT INFORMATION

We encourage you to authorize your monthly payment to be automatically deducted from your checking and/or savings account each month. Direct debits will be processed on the fifth day of the month, or the first working day following the fifth day if it occurs on a weekend or holiday. In order for Direct Debit to be effective the fifth of the following month, the current month coverage must be paid and the Direct Debit form must be received by the 20th of the month preceding the month you want Direct Debit to begin. If the Administration Office receives the authorization form after the 20th of the month, Direct Debit will begin on the fifth day of the following month (i.e. one month delay).

Authorization Received by Admin Office	First Direct Debit
Before March 20	April 5
After March 20	May 5
After April 20	June 5

If there are **not sufficient funds** in your account to cover your payment, the Direct Debit will be cancelled. You must then send a payment check plus \$10.00 handling fee to cover bank charges for the NSF (not sufficient funds) Direct Debit.

To take advantage of this payment option, please return the completed form (along with a voided check) by the 20th of the month.

The Trustees wish to reiterate that Retiree benefits are not guaranteed, and there is no liability on the part of the Board of Trustees to provide payment over and above the amounts collected and available for such purpose. The Trustees reserve the right to change or discontinue the types and amounts of benefits under these plans, and the eligibility rules, in any manner in which they in their sole discretion determine to be prudent. The nature and amount of plan benefits are always subject to the actual terms of the plan as it exists at the time the claim occurs.

Furthermore, the benefits available to Retirees may be changed or eliminated at any time by action of the Trustees or by action of the participating employers and union. A change or termination of benefits will apply to individuals who have already retired as to future retirees.

Please return your completed Direct Debit Authorization Form (next page) if you elect your monthly payment to be automatically deducted from your checking and/or savings account each month



**THE EAST BAY
DRAYAGE DRIVERS
SECURITY FUND**

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400 Roland Way
Oakland, CA 94621
(855) 263-7242 ♦ (925) 954-1439**

DIRECT DEBIT AUTHORIZATION FORM

If you would like to participate in the Direct Debit Program, please do one of the following: I authorize East Bay Drayage Security Fund to debit my:

- Checking account, please complete the form below, sign and attach a voided check. The voided check is for information purposes only
- Savings account, please complete the form below and sign it.

Name on Account: _____	
Bank Name: _____	
Account Number _____	
Routing Number _____	
Amt. to Debit _____ <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	
_____	_____
Your Signature	Date

***ATTACH VOIDED CHECK HERE
and return this form to:***

EAST BAY DRAYAGE SECURITY FUND
Local 70 Health & Welfare Office
400 Roland Way, Oakland, CA 94621

Date: _____

Western Conference of Teamsters Pension Trust

1000 Marina Blvd, Ste 400

Brisbane, CA 94005

Re: *Retirement Verification Document Request*

To Whom it May Concern,

I am a new retiree with the East Bay Drayage Drivers Security Fund. I am sending you this letter to authorize Corcoran Administrators, Claudia Herrera, and Katelyn Chan to collect from you any documentation that confirms my status as a retiree, verifies pension activation, states my years of service, or states my effective date of retirement.

This documentation is required proof for me to activate my retiree medical coverage.

Sincerely,

Retiree Signature

Print Name