



## ADDENDUM to PARTICIPATION AGREEMENT for Health and Welfare Coverage

This Addendum is for use when more than one set of rates apply to any coverage election (e.g. when more than one medical, dental, vision, etc. benefit option is offered; or when different benefit option and/or rates apply for actives versus Medicare retirees, or different job classifications where appropriate, etc.).

EMPLOYER NAME: \_\_\_\_\_

### II. COVERAGE ELECTION AND MONTHLY CONTRIBUTION - CONTINUED

*(This Addendum continues from primary Participation Agreement. Refer to that document for applicable rules and instructions.)*

A. ☐ **MEDICAL** Benefit option: \_\_\_\_\_ Coverage effective date: \_\_\_\_\_

**ELIGIBLE CLASS:** \_\_\_\_\_

<input type="checkbox"/> Two tier rates	<input type="checkbox"/> Three tier rates	<input type="checkbox"/> Four tier rates
Employee: _____	Employee: _____	Employee: _____
Family: _____	Employee+1: _____	EE+Spouse: _____
	Family: _____	EE+Child(ren): _____
		Family: _____

B. ☐ **MEDICAL** Benefit option: \_\_\_\_\_ Coverage effective date: \_\_\_\_\_

**ELIGIBLE CLASS:** \_\_\_\_\_

<input type="checkbox"/> Two tier rates	<input type="checkbox"/> Three tier rates	<input type="checkbox"/> Four tier rates
Employee: _____	Employee: _____	Employee: _____
Family: _____	Employee+1: _____	EE+Spouse: _____
	Family: _____	EE+Child(ren): _____
		Family: _____

C. ☐ **DENTAL** Benefit option: \_\_\_\_\_ Coverage effective date: \_\_\_\_\_

**ELIGIBLE CLASS:** \_\_\_\_\_

Monthly rate: \_\_\_\_\_ Employee: \_\_\_\_\_ Family: \_\_\_\_\_ Composite (legacy): \_\_\_\_\_

D. ☐ **VISION** Benefit option: \_\_\_\_\_ Coverage effective date: \_\_\_\_\_

**ELIGIBLE CLASS:** \_\_\_\_\_

Monthly rate: \_\_\_\_\_ Employee: \_\_\_\_\_ Family: \_\_\_\_\_ Composite (legacy): \_\_\_\_\_

E. ☐ **DISABILITY** Benefit option: \_\_\_\_\_ Coverage effective date: \_\_\_\_\_

**ELIGIBLE CLASS:** \_\_\_\_\_

Monthly rate: \_\_\_\_\_ *Short Term Disability Income Coverage is an employee only benefit.*

F. ☐ **LIFE AND AD&D** Benefit option: \_\_\_\_\_ Coverage effective date: \_\_\_\_\_

**ELIGIBLE CLASS:** \_\_\_\_\_

Dependents covered? ☐

Benefit amount (employee only): \_\_\_\_\_ Monthly rate: \_\_\_\_\_

Dependent benefit amount (legacy): \_\_\_\_\_ Monthly rate: \_\_\_\_\_

**EMPLOYER AND UNION ACCEPTANCE** - Employer and Union representatives must initial and date this Addendum to show agreement with the above noted coverage elections and rates. This Addendum will be attached to and become a part of the associated Participation Agreement, subject to all rules thereof.

\_\_\_\_\_  
Employer Representative Initials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Union Representative Initials

\_\_\_\_\_  
Date

Addendum \_\_\_\_\_ of \_\_\_\_\_

Revised 1/13/2015