SEAFARERS HEALTH AND BENEFITS PLAN
SEAFARERS PENSION PLAN

5201 Capital Gateway Drive
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

IMPORTANT! IF YOU ARE NOT ELIGIBLE FOR MEDICARE YOU MUST FILL OUT AND RETURN THIS FORM TO RECEIVE PENSIONER HEALTH BENEFITS.

If you are not eligible for Medicare at the time you retire, you are required to pay a monthly premium to maintain health coverage. The amount of this premium is $100 for individual coverage, or $200 for family coverage (for two or more individuals who are not eligible for Medicare). If you are eligible for Medicare but your spouse is not, you must pay a $100 premium for your spouse's coverage, or $200 for your spouse and dependent children. The Seafarers Pension Plan will deduct this premium from your pension benefit, if you give the Plan written permission to make this deduction, so that you do not have to send monthly payments to us. These deductions will automatically stop when all family members covered by the Plan are eligible for, and enrolled in Medicare (you must notify SHBP that you are enrolled in Medicare).

I,_____, Last 4 digits of SSN_____, DOB_____, voluntarily authorize the Seafarers Pension Plan to pay a portion of my monthly pension benefit to the Seafarers Health and Benefits Plan (SHBP) for my monthly health care premium.

Please read all of the choices below, then check all that apply.

☐ I direct the Plan to deduct $100.00 per month from my pension benefit for one person.

☐ I direct the Plan to deduct $200.00 per month from my pension benefit for family health coverage (two or more people).

☐ I will pay premiums by check or money order, three months in advance.

☐ I do not want to receive health coverage from Seafarers Health and Benefits Plan. I understand that if I opt out, I **cannot opt back in** at a later time.

☐ I do not want to receive health coverage from Seafarers Health and Benefits Plan for my dependents. I understand that if they opt out, they **cannot opt back in** at a later time. All dependents must sign and date this form.

I understand that this authorization is revocable at any time by writing to the Administrator at theabove address. However, I acknowledge that if I revoke this authorization and want to continue my health coverage, I will be required to make payments to the Seafarers Health and Benefits Plan every three months in advance, ($300.00 for single coverage and $600.00 for family coverage). **In the event that the premiums are not paid in a timely manner, I understand that the Seafarers Health and Benefits Plan will terminate my health coverage.**

_____	_____	_____
Print Name	Signature	Date Signed
_____	_____	_____
Print Dependent Name	Dependent Signature	Date Signed

This form must be returned within 90 days or you will lose eligibility for health benefits.
Return form to: SHBP Claims Department, 45353 Saint Georges Avenue, Piney Point, MD 20674.