# HEALTH HOURS ESTIMATION REQUEST

Local No. _____

Name _____ Social Security No. _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip)

Telephone (_____)_____ Date of Birth _____

## RETIREE HEALTH PLAN ELIGIBILITY REQUIREMENTS

**ELIGIBLE RETIREES**

You are eligible for the Retiree Health Plan **if** you are a Local Union 11 pensioner who has retired and receives benefits from the Southern California IBEW-NECA Pension Plan, **and if** you meet the following requirements **as of the original pension effective date**:

1. You are 55 years old or older (*) and have accumulated at least 25 years of Credited Service under the Southern California IBEW-NECA Pension Plan,

**OR**

You are 62 years old or older and have accumulated at least 10 years of Credited Service under the Pension Plan.

**AND**

2. At the time of your retirement, you have accumulated at least 10,500 hours contributed to the Southern California IBEW-NECA Health Plan (including Health hours sent through I.O. reciprocity) in 7 of the 10 years immediately preceding the date of your retirement,

**OR**

3. At the time of your retirement, you have accumulated at least 30,000 hours contributed to the Southern California IBEW-NECA Health Plan (includes Health hours sent through the I.O. reciprocity).

**AND**

4. You elect coverage and pay a portion of the cost of your benefits (self-payment) and those of your spouse, as explained on page 27 of the Retiree Health Plan Summary Plan Description.

**AND**

5. You have **not** engaged in Non-Covered Electrical Employment since first attaining initial eligibility for coverage under the Active Health Plan.

***Note**: Those retiring between the ages of 50-55 on or after July 1, 2000 may qualify by working under the maintenance program as explained in the enclosed notice.

**TOTAL DISABILITY OR PARTIAL DISABILITY RETIREES**

A Total Disability retiree need only meet requirements 2, 4, and 5 or 3,4 and 5. A Partial Disability retiree must be at least age 50 and need only meet requirements 2, 4, and 5 or 3,4 and 5.

**RETIREMENT** – Check **one** only

☐ Request review of Health Hours for a participant taking early or normal retirement from Pension Fund.

☐ Request review of Health Hours for a participant taking disability retirement from Pension Fund.

**X**_____
Participant Signature Printed Name Date Signed

**Office Use Only:** Current Eligibility: _____ Effective Date: _____ Initials/Date: _____