Your Future — Our Focus

Chicago Regional Council of Carpenters
Welfare, Pension and Supplemental Retirement Funds

12 East Erie Street • Chicago, Illinois 60611
(312) 787-9455 • Kristina M. Guastaferri, Administrator
www.crccbenefits.org

January 2017

Dental Benefit -- New Premiums & Annual Open Enrollment Opportunity

Dear Retired Participant and Family Members:

The Trustees of the Chicago Regional Council of Carpenters Welfare Fund ("Plan") announce the annual open enrollment opportunity for the insured dental plan through Delta Dental of Illinois. On the reverse side of this announcement, you will find a "Delta Dental Benefit Highlight Sheet" that explains the coverage under this plan. As the benefit is an insured dental plan, Delta Dental sets the premium rates.

Effective April 1, 2017, for those who are already enrolled and for those who elect to enroll during the open enrollment period, monthly premium rates for the next twelve months are listed below. Please note that premiums may increase in the future.

Dental Coverage Type	Monthly Premium Amount
Single (1 person enrolled)	$ 42.92
Single + 1 (2 individuals enrolled)	$ 83.30
Family (3 or more individuals enrolled)	$147.80

Premium payments can only be handled as a deduction from your monthly pension check. However, if the total premium for coverage under the Retiree Plan of benefits is greater than the amount of the monthly pension payment, arrangements can be made for you to pay the difference directly to the Fund Office.

To Elect Dental Coverage: *If you are already enrolled in the dental coverage, you do NOT need to re-enroll. Use the enclosed dental enrollment form only to add coverage for individuals that are not currently enrolled in the dental coverage.* For new enrollments, complete and return the enclosed Enrollment Form no later than March 3, 2017. Send the completed Enrollment Form via fax to (312) 951-3986; or scan and email to pension@crccbenefits.org; or mail to CRCC Pension Fund, Attn: Retirement Benefits Department, 12 E. Erie Street, Chicago, IL 60611.

Enrollment Forms submitted after March 3, 2017 (postmark date) will not be accepted. You will be required to wait until next year's open enrollment period. If you, your spouse, or your dependent children have dental coverage with another insurance plan you may postpone enrollment in this plan until coverage under the other plan ends.

Finding a network provider: The Delta Dental PPO & Premier program has the nation's largest dental network, offering you access to a wide range of participating network dental providers who have agreed to charge lower fees for their services. Using a Delta Dental network provider will save you money. Your Plan gives you access to both the PPO and Premier networks. To find out if your dentist participates in the Delta Dental network, visit Delta Dental of Illinois' website at www.deltadentalil.com. To obtain a list of providers in your area, click on "Find a Network Dentist" and select a network.

If you have questions about the dental benefits, please call Delta Dental at 1-800-323-1743 between 7:00 am and 7:00 pm CST to speak to a Delta Dental representative. Mention that you are in Delta Group #20343.

To Cancel Dental Coverage: If you are currently enrolled in dental coverage and are electing to cancel coverage effective April 1, 2017, complete and return the enclosed Cancellation Form no later than March 15, 2017 (postmark date). Be aware that, if an individual received covered dental services and then cancels coverage before being enrolled in dental coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

If you have questions about this notice, please contact the Retirement Benefits Department Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. (CST) at (312) 787-9455, menu option 4.

Sincerely,

The Board of Trustees

DELTA DENTAL

Dental Benefit Highlight Sheet

Chicago Regional Council of Carpenters Welfare Fund
Retiree Plan of Benefits – Delta Group #20343

Who's Eligible	**Participant, Spouse and dependent children to age 26 – when enrolled and monthly premiums are paid**
Annual Deductible (applies to Basic and Major Services Only)	**$50/person; $150/family (3 or more)**
Annual Maximum	**$1,500/person**
Enhanced Benefits Program	**Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.**

	Delta Dental PPO Network Dentist	Delta Dental Premier® Network Dentist	Non-Network Dentist
PREVENTIVE/DIAGNOSTIC SERVICES • oral evaluations (two in 12 month period) • X-rays (bitewings two in 12 month period; full mouth or panoramic once in 36 month period; cephalometric once in 24 month period) • prophylaxis (cleaning; two in 12 month period) • fluoride treatment (once in 12 month period for children under age 19) • sealants (1st & 2nd molars only for dependents under age 15) • palliative treatment	100%*	100% **	100%***
BASIC SERVICES • fillings • oral surgery • periodontics • endodontics • removal of cysts & tumors • general anesthesia (in conjunction w/ oral surgery) • consultations • space maintainers	80%*	80%**	80%***
MAJOR RESTORATIVE SERVICES • crowns, jackets, cast restorations • fixed/removable bridges • partial/full dentures • implants and related procedures	50%*	50%**	50%***
ORTHODONTIA AND RELATED SERVICES	No coverage		

* Delta Dental PPO dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's allowed PPO fee. PPO network dentists cannot charge you for costs exceeding the PPO fee.

** Delta Dental Premier dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. Premier dentists may not charge you for costs exceeding the maximum plan allowance.

*** Non-network dentists (non-Delta Dental PPO/non-Delta Dental Premier) do not agree to accept Delta Dental's allowed fees as payment in full; payment is based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. These dentists can charge you for costs exceeding the maximum plan allowance.

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January 2017

Vision Benefit Enrollment Opportunity

Dear Retired Participant and Family Members:

As Trustees of the Chicago Regional Council of Carpenters Welfare Fund ("Plan"), we continually review your benefits to ensure you have access to quality and competitive benefit coverage that meets your needs. We are pleased to announce the offering of an insured vision plan through Delta Dental of Illinois' DeltaVision® program. The DeltaVision® program uses the EyeMed Insight network of providers. Enclosed you will find a "DeltaVision® Benefit Highlight" document which explains the coverage that you can elect.

For those who elect to enroll, coverage and premium payments begin April 1, 2017. Monthly premium rates for the next twelve months are listed below. Please note that premiums may increase in the future.

Vision Coverage Type	Monthly Premium Amount
Single (1 person enrolled)	$6.16
Single +1 (2 individuals enrolled)	$12.01
Family (3 or more individuals enrolled)	$17.99

Premium payments will be handled as a deduction from your monthly pension check. However, if the total premium for all elected benefits is greater than your monthly pension payment, arrangements can be made for you to pay the difference directly to the Fund Office.

To Elect Vision Coverage: Complete and return the enclosed Enrollment Form no later than March 3, 2017. Send the completed Enrollment Form in any of these ways:

- Via fax to (312)951-3986; or
- Scan and email to: pension@crccbenefits.org; or
- Mail to: CRCC Pension Fund, Attn: Retirement Benefits Department, 12 E. Erie Street, Chicago, IL 60611.

Enrollment Forms submitted after March 3, 2017 (postmark date) will not be accepted. You will be required to wait until next year's open enrollment period. If you have other vision coverage, you may postpone enrollment in this plan until your other coverage ends. If an individual enrolls in vision coverage, has services, and then cancels coverage before being enrolled in vision coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

Finding a network provider: To locate an in-network provider search the online provider directory at www.deltadentalil.com. Click on "Provider Search," and then "Find a Vision Provider." You will be redirected to the EyeMed site. Here, you can key in your zip code and select the INSIGHT network of vision care providers to find a provider near you. **If you have questions about the vision benefits, please call Delta at 1-800-323-1743** between 7:00 am and 7:00 pm CST to speak to a representative. Mention that you are in Delta Group #20343 and are calling about the benefits offered under the DeltaVision Insight program.

If you have questions about this notice, please contact the Retirement Benefits Department Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. (CST) at (312) 787-9455, menu option 4.

Sincerely,

The Board of Trustees

DELTA DENTAL®

Delta Dental of Illinois

DeltaVision® Benefit Highlight Insight Network

Chicago Regional Council of Carpenters Welfare Fund - Retirees

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks. DeltaVision offers members vision care benefits that combine choice, value and wellness. Your DeltaVision program provides vision care insurance to you (and your family, if applicable) according to the following information.

Vision Care Services	Insight Network Member Cost (Edge)	Out-of-Network Allowance
Exam with Dilation as Necessary:	$10 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	Member pays up to $55 for fit and two follow-up visits	N/A
Premium**	10% off retail price	N/A
Frames: (Any available frame at provider location)	$130 allowance, 20% off balance over allowance	$65
Standard Plastic Lenses:		
Single Vision	$25 Copay	$25
Bifocal	$25 Copay	$40
Trifocal	$25 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (In addition to Bifocal copay)	$65	$40
Premium Progressive – (in addition to Bifocal copay)	Tier 1 - $85, Tier 2 - $95, Tier 3- $110, Tier 4 - $65, 80% of retail, less $120 allowance	$40
Standard Anti-Reflective Coating	$45	N/A
Premium Anti –Reflective Coating	Tier 1 - $57, Tier 2 - $68, Tier 3 – 80% of charge	N/A
Photocromatic/Transition Plastic	$65	N/A
Polarized	80% of charge	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings, other than Standard Contact Lenses (Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at in-network providers on items not covered by the program. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or an in-network provider's professional services. Retail prices may vary by location.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses at in-network providers once the funded benefit has been used.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www deltadentalil.com/deltavision. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: DeltaVision enrollees can receive a discount of 15% off retail price or 5% off promotional price from select providers. Please contact us at www.deltadentalil.com/deltavision or 866-723-0513 for a current list of LASIK/PRK providers.

Network Information

You may choose to go to any licensed optometrist, ophthalmologist and/or dispensing optician whenever you need vision care. However, there may be significant cost advantages when you receive treatment from an in-network provider.

We offer two easy ways to locate an in-network provider 7 days a week, 24 hours a day. You can either:

- search our online Provider directory at www.deltadentalil.com/deltavision; or
- use the automated phone system by calling 1-866-723-0513

Using Your Vision Program

1. Have your DeltaVision information card available when scheduling and visiting an in-network provider. An in-network provider is one who participates in the EyeMed Vision Care Provider network. **It's very important that you know which network your benefit plan utilizes (your plan uses the Insight network).** You will only receive in-network benefits from Insight network providers. Please note: the network provider will need the primary enrollee's name and date of birth to verify eligibility.

2. Pay your copayment and any other charges not covered at the time of service. No paperwork is required. You continue to save on additional eyewear purchases any time you present your card to an in-network provider.

3.If you select a provider who is not in the network, you do not receive preferred pricing and you may be asked to provide full payment to your out-of-network provider at the time of service. To receive benefit reimbursement, submit a completed claim form (available on our website), along with itemized receipts from your provider and your prescription to:

DeltaVision Claims Processing
c/o EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Exclusions

In no event will coverage exceed the lesser of:
1. the actual cost of Covered Services or Materials or
2. the limits of the Policy, shown in the Schedule.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period.

Benefits may not be combined with any discount, promotional offering or other group benefit programs.

Benefit allowances provide no remaining balance for future use within the same benefit period.

There is no coverage for professional services or materials connected with:

1. Orthoptic or vision training, sub-normal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes or supporting structures;
4. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under this program;
5. Services provided as a result of any Workers' Compensation law;
6. Plano lenses (lenses that have no refractive power), non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. Two pair of glasses in lieu of bifocals.

The preceding information is a brief summary of Chicago Regional Council of Carpenters Welfare Fund - Retirees Edge Vision Program and the services it covers.

If you have specific questions regarding benefit coverage, limitations or exclusions, contact our customer service department at 1-866-723-0513.

Delta Dental of Illinois
111 Shuman Blvd
Naperville, IL 60563
800-335-8215
www.deltadentalil.com/deltavision

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NONDISCRIMINATION STATEMENT

The Chicago Regional Council of Carpenters Welfare Fund (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, telephone or in person at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Cindy Rivera, Civil Rights Coordinator, 12 E. Erie Street, Chicago, IL 60611, Phone: 312-787-9455.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

* * *

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-787-9455.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-787-9455.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-312-787-9455.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-312-787-9455 (번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-312-787-9455.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-312-9455-787

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-312-787-9455.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-312-787-9455.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-312-787-9455.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-312-787-9455.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-312-787-9455.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-312-787-9455 पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-312-787-9455.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-312-787-9455.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-312-787-9455.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS

12 East Erie Street, Attn: Retirement Benefits Dept., Chicago, Illinois 60611
Fax: (312)951-3986 -- **Email:** pension@crccbenefits.org
Phone (312)787-9455, option #4

RETIREE DENTAL BENEFITS APRIL 1, 2017 CANCELLATION FORM

Provided that this completed cancellation form is returned to the Retirement Benefits Department by March 15, 2017 (postmark date), dental benefits will be cancelled for April 1, 2017 in accordance with the elections made below.

If an individual received covered dental services, and then cancels coverage before being enrolled in dental coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

Participant's Name (**PLEASE PRINT**): _____

Participant's UID# or SS#: _____

Participant's Street Address, City, State & Zip:_____

Participant's Home Phone Number: _____ Cellular Phone Number: _____

Participant's E-Mail Address: _____

CHECK THE APPROPRIATE CIRCLE(S):

O Effective April 1, 2017, I elect to CANCEL my (the carpenter's) dental coverage. I understand that, if I have a spouse and/or other dependents covered under the dental coverage, this coverage will also be cancelled for them.

O I elect to CANCEL the dental coverage for my SPOUSE. **Spouse's Name** _____

O I elect to CANCEL the dental coverage for my DEPENDENT CHILD**. Dependent's Name** _____

O I elect to CANCEL the dental coverage for my DEPENDENT CHILD**. Dependent's Name** _____

O I elect to CANCEL the dental coverage for my DEPENDENT CHILD**. Dependent's Name** _____

Participant's Signature:_____

Date Signed by Participant:_____

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

DENTAL ENROLLMENT

* I N S D E N T A L *

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS

Fax: (312) 951-3986 – **Email**: pension@crccbenefits.org
12 East Erie Street, Attn: Retirement Benefits Dept., Chicago, IL 60611
Phone: (312) 787-9455 – Option # 4

2017 Annual Open Enrollment Form for Dental Coverage under the Retiree Plan

***** IMPORTANT: If you are already enrolled in the dental coverage, you do NOT need to return this form. *****
*****Use this form ONLY to ADD coverage for individuals that are not currently enrolled. *****

Instructions: **Print Clearly in Ink**. This form is used to enroll in Dental Coverage under the Retiree Plan of Benefits. The retired carpenter must complete this form in full, sign and date it. This is a 2 page form. Both pages of the completed form must be submitted to the Retirement Benefits Department.

If you do not add coverage by March 3, 2017 (postmark date), you will need to wait until next year's open enrollment period unless you postpone coverage due to other dental insurance.

Participant's Name:	**Participant's SSN# or UID#** (UID# is on BCBS I.D. Card)	
Participant's Street Address, City, State & Zip:		**Participant's Date of Birth:** / /
Participant's E-Mail Address:	**Participant's Home Phone Number:**	**Participant's Cellular Phone Number:**

Participant Dental Coverage Election

By completing, signing and returning this enrollment form to the Fund Office, I, the retired participant, am electing to enroll in the Dental Coverage under the Retiree Plan of Benefits.

Note: If you do not want to enroll, you should not return this form to the Fund Office. Remember that your spouse and/or your dependent children can only enroll if you, the retired carpenter, enroll.

Spouse Information/Coverage Election		
Spouse's Name:	Spouse's SSN (Mandatory):	Spouse's Date of Birth: / /

Spouse Dental Coverage Election – Your spouse can only enroll if you, the retired carpenter, enroll. If your spouse is not currently covered by medical or prescription drug benefits under the Retiree Plan of Benefits, and you are electing to enroll your spouse in the Dental Coverage, then you must submit an original county certified birth certificate for your spouse and an original county certified marriage document.

Choose One

- ☐ My spouse elects to enroll in the Dental Coverage under the Retiree Plan of Benefits
- ☐ My spouse does NOT wish to enroll in the Dental Coverage under the Retiree Plan of Benefits
- ☐ My spouse is covered by another Dental plan and elects to postpone enrollment in the Dental Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

(OVER)

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

1. Child's Last Name First Middle Initial	Child's Date of Birth / /	Child's Gender: □ Male □ Female	Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain:
Does the above named child live at same address as Participant: □ Yes □ No If no, list address:		Child's Soc. Sec. Number **(Mandatory)**	

Dependent Child Dental Coverage Election - Your dependent child(ren) can only enroll if you, the retired carpenter, enroll. If your dependent child is not currently covered by medical or prescription drug benefits under the Retiree Plan of Benefits, and you are electing to enroll your dependent child in the Dental Coverage, then you must submit an original county certified birth certificate for your dependent child.

Choose One

- ☐ I elect to enroll my dependent child in the Dental Coverage under the Retiree Plan of Benefits (see reverse side for list of dependents)
- ☐ I elect not to enroll my dependent child in the Dental Coverage under the Retiree Plan of Benefits
- ☐ My dependent child is covered by another Dental plan and elects to postpone enrollment in the Dental Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

2. Child's Last Name First Middle Initial	Child's Date of Birth / /	Child's Gender: □ Male □ Female	Relationship to Participant: □ Son □ Daughter □ Step Child □ Other –Explain:
Does the above named child live at same address as Participant: □ Yes □ No If no, list address:		Child's Soc. Sec. Number **(Mandatory)**	

Dependent Child Dental Coverage Election - Your dependent child(ren) can only enroll if you, the retired carpenter, enroll. If your dependent child is not currently covered by medical or prescription drug benefits under the Retiree Plan of Benefits, and you are electing to enroll your dependent child in the Dental Coverage, then you must submit an original county certified birth certificate for your dependent child.

Choose One

- ☐ I elect to enroll my dependent child in the Dental Coverage under the Retiree Plan of Benefits (see reverse side for list of dependents)
- ☐ I elect not to enroll my dependent child in the Dental Coverage under the Retiree Plan of Benefits
- ☐ My dependent child is covered by another Dental plan and elects to postpone enrollment in the Dental Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

Do you need to list more dependents? ☐ Yes ☐ No If yes, please list them on another piece of paper and return with this form.

I hereby authorize **either** the Chicago Regional Council of Carpenters Pension Fund **or** the Chicago Regional Council of Carpenters Millmen Pension Fund **or** the Carpenters Pension Fund of Illinois **or** the Carpenters Local #496 Pension Fund (hereafter referred to as "Pension Fund") to deduct the appropriate premium(s) from my monthly pension benefit for the coverage under the Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits ("Welfare Fund") that I have elected. I understand that premium rates may increase at any time. If premiums increase under the Welfare Fund, the Pension Fund is authorized to withhold the increased premium amount from my pension payment.

It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the information that I have furnished on this form is untrue or incomplete, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided.

Signature of Participant: _____ **Date**: _____

Receipt of this form does not guaranty eligibility.

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

VISION ENROLLMENT

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS
Fax: (312) 951-3986 – **Email**: pension@crccbenefits.org
12 East Erie Street, Attn: Retirement Benefits Dept., Chicago, IL 60611
Phone: (312) 787-9455 – Option #4

* I N S V I S I O N *

2017 Enrollment Form for Vision Coverage under the Retiree Plan

Instructions: **Print Clearly in Ink**. This form is used to enroll in Vision Coverage under the Retiree Plan of Benefits. The retired carpenter must complete this form in full, sign and date it (on the reverse side). This is a 2 page form. Both pages of the completed form must be submitted to the Retirement Benefits Department.

Important: *If you or your dependents do not enroll by March 3, 2017 (postmark date), you will need to wait until next year's open enrollment period unless you postpone coverage due to other vision insurance.*

Participant's Name:	**Participant's SSN# or UID#** (UID# is on BCBS I.D. Card)	
Participant's Street Address, City, State & Zip:		**Participant's Date of Birth:** / /
Participant's E-Mail Address:	**Participant's Home Phone Number:**	**Participant's Cellular Phone Number:**

Participant Vision Coverage Election

By completing, signing and returning this enrollment form to the Fund Office, I, the retired participant, am electing to enroll in the Vision Coverage under the Retiree Plan of Benefits.

Note: If you do not want to enroll, you should not return this form to the Fund Office. Remember that your spouse and/or your dependent children can only enroll if you, the retired carpenter, enroll.

Spouse Information/Coverage Election

Spouse's Name:	Spouse's SSN (Mandatory):	Spouse's Date of Birth: / /

Spouse Vision Coverage Election – Your spouse can only enroll if you, the retired carpenter, enroll. If your spouse is not currently covered by medical, prescription drug, or dental benefits under the Retiree Plan of Benefits, and you are electing to enroll your spouse in the Vision Coverage, then you must submit an original county certified birth certificate for your spouse and an original county certified marriage document.

Choose One

- ☐ My spouse elects to enroll in the Vision Coverage under the Retiree Plan of Benefits
- ☐ My spouse does NOT wish to enroll in the Vision Coverage under the Retiree Plan of Benefits
- ☐ My spouse is covered by another Vision plan and elects to postpone enrollment in the Vision Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

Dependent Children Information/Coverage Election (Continues on Other Side)

1. Child's Last Name First Middle Initial	Child's Date of Birth / /	Child's Gender: ☐ Male ☐ Female	Relationship to Participant: ☐ Son ☐ Daughter ☐ Step Child ☐ Other -Explain:
Does the above named child live at same address as Participant: ☐ Yes ☐ No If no, list address:		Child's Soc. Sec. Number **(Mandatory)**	

Dependent Child Vision Coverage Election - Your dependent child(ren) can only enroll if you, the retired carpenter, enroll. If your dependent child is not currently covered by medical, prescription drug, or dental benefits under the Retiree Plan of Benefits, and you are electing to enroll your dependent child in the Vision Coverage, then you must submit an original county certified birth certificate for your dependent child.

Choose One

- ☐ I elect to enroll my dependent child in the Vision Coverage under the Retiree Plan of Benefits (see reverse side for list of dependents)
- ☐ I elect not to enroll my dependent child in the Vision Coverage under the Retiree Plan of Benefits
- ☐ My dependent child is covered by another Vision plan and elects to postpone enrollment in the Vision Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

2. Child's Last Name First Middle Initial	Child's Date of Birth / /	Child's Gender: □ Male □ Female	Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain:
Does the above named child live at same address as Participant: □ Yes □ No If no, list address:		Child's Soc. Sec. Number **(Mandatory)**	

Dependent Child Vision Coverage Election - Your dependent child(ren) can only enroll if you, the retired carpenter, enroll. If your dependent child is not currently covered by medical, prescription drug, or dental benefits under the Retiree Plan of Benefits, and you are electing to enroll your dependent child in the Vision Coverage, then you must submit an original county certified birth certificate for your dependent child.

Choose One

- ☐ I elect to enroll my dependent child in the Vision Coverage under the Retiree Plan of Benefits (see reverse side for list of dependents)
- ☐ I elect not to enroll my dependent child in the Vision Coverage under the Retiree Plan of Benefits
- ☐ My dependent child is covered by another Vision plan and elects to postpone enrollment in the Vision Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

3. Child's Last Name First Middle Initial	Child's Date of Birth / /	Child's Gender: □ Male □ Female	Relationship to Participant: □ Son □ Daughter □ Step Child □ Other –Explain:
Does the above named child live at same address as Participant: □ Yes □ No If no, list address:		Child's Soc. Sec. Number **(Mandatory)**	

Dependent Child Vision Coverage Election - Your dependent child(ren) can only enroll if you, the retired carpenter, enroll. If your dependent child is not currently covered by medical, prescription drug, or dental benefits under the Retiree Plan of Benefits, and you are electing to enroll your dependent child in the Vision Coverage, then you must submit an original county certified birth certificate for your dependent child.

Choose One

- ☐ I elect to enroll my dependent child in the Vision Coverage under the Retiree Plan of Benefits (see reverse side for list of dependents)
- ☐ I elect not to enroll my dependent child in the Vision Coverage under the Retiree Plan of Benefits
- ☐ My dependent child is covered by another Vision plan and elects to postpone enrollment in the Vision Coverage under the Retiree Plan of Benefits until coverage under the other plan ends.

Do you need to list more dependents? □ Yes □ No If yes, please list them on another piece of paper and return with this form.

I hereby authorize **either** the Chicago Regional Council of Carpenters Pension Fund **or** the Chicago Regional Council of Carpenters Millmen Pension Fund **or** the Carpenters Pension Fund of Illinois **or** the Carpenters Local #496 Pension Fund (hereafter referred to as "Pension Fund") to deduct the appropriate premium(s) from my monthly pension benefit for the coverage under the Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits ("Welfare Fund") that I have elected. I understand that premium rates may increase at any time. If premiums increase under the Welfare Fund, the Pension Fund is authorized to withhold the increased premium amount from my pension payment.

It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the information that I have furnished on this form is untrue or incomplete, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided.

Signature of Participant: _____ **Date**: _____

Receipt of this form does not guaranty eligibility.

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE