

DEFERRAL OF HEALTH BENEFITS FORM (Seasonal Employees Only)

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
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Use this form only if you choose to elect a deferral of the effective date of your health benefits. By completing and submitting this form, the effective date of your health benefits will be delayed by one month (or two months) past the date your coverage would otherwise become effective; and termination of your health benefits will be delayed by one month (or two months) past the date your coverage would otherwise terminate. **A deferral form that is signed and submitted to the Health Trust Administrator cannot be revoked. If you do not wish to defer your benefits do not use this form.**

New Employees: As a newly hired seasonal employee your health benefits take effect on the first day of the month following 30

consecutive days in paid status, provided your health benefit contributions have been reported to the ASEA Health Trust on your behalf. Once you have established eligibility, your coverage remains in effect through the last day of the month in which you were in paid status or in which you began seasonal overtime conversion.

Employees returning to work: As a returning seasonal employee your health benefits take effect on the first day you return to work, provided you and your employer pay health benefit contributions to the ASEA Health Trust. Without a deferral, your coverage remains in effect through the last day of the month in which you were in paid status or began seasonal overtime conversion.

One Month Deferral Examples	New Employees		Employees Returning to Work	
	No deferral	With deferral	No deferral	With deferral
Hire date:	March 8	March 8	N/A	N/A
Return to work date:	N/A	N/A	April 21	April 21
Effective date of coverage:	May 1	June 1	April 21	May 21
First day of seasonal leave:	August 16	August 16	September 5	September 5
Coverage termination date:	August 31	September 30	September 30	October 31

I choose to defer the effective date of my health benefits by: 1 Month 2 Months

Hire date or Return to Work date (required):

Employee Name:

Alternate ID Number:

Work Phone Number:

Home or Cell Number:

Address:

City/State/Zip:

CERTIFICATION

By signing below I understand that:

- I am electing to have the effective date of my health benefits deferred;
- that this deferral will have no effect on any optional coverage I may have elected (i.e. Health Care Reimbursement Account);
- the deferral will be used when I take seasonal leave without pay and cannot be carried over into the next return-to-work period;
- I must submit a new form each time I return to work if I wish to have my benefits deferred;
- and that this deferral cannot be revoked.

Employee signature:

Date:

The DEFERRAL OF HEALTH BENEFITS FORM must be postmarked or faxed to the ASEA/AFSCME Local 52 Health Benefits Trust within 30 days of the date you start seasonal employment or return to work from seasonal leave. You must also give a copy to your Departmental Personnel Office. It is your responsibility to make sure this form is received by the Health Trust Administrator.

Please Note: A deferral election is used once an employee takes SLWOP (Seasonal Leave Without Pay) and cannot be carried over into the next return-to-work period. Seasonal employees must sign a new deferral each time they return to work from SLWOP and want to defer their health benefits coverage